

THE MEDICAL JOURNAL OF AUSTRALIA

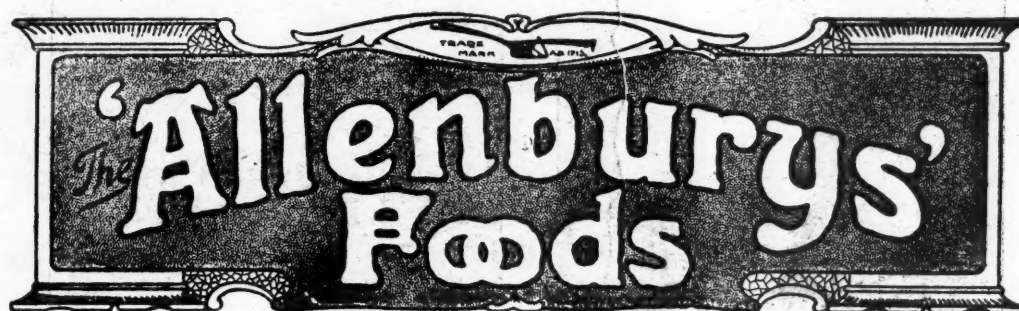
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The Journal of the Australian Branches of the British Medical Association.

VOL. I.—4TH YEAR—No. 14.

SYDNEY: SATURDAY, APRIL 7, 1917.

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VIROL

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No. 14.

An Address

By **Sinclair Gillies, M.D., Lond., D.P.H., Cantab.,**

Retiring President, New South Wales Branch of the British Medical Association.

Not the least onerous of the duties of the occupant of the Presidential Chair is the delivery on his last night of office of a Presidential Address. The occasion is one of considerable responsibility and anxiety. For, while, on the one hand, there is the comfortable feeling that for once he is free to express his views without fear of immediate overt criticism, yet this very freedom confines to somewhat narrow bounds from fear of taking unfair advantage of such unwanted liberty.

In years gone by this address was the opportunity for mounting one's scientific hobby horse, and straying into the wide fields of speculative research or the narrower lanes of special knowledge. Very instructive and enjoyable such excursions often proved. Of later years, with the growth of our Association in importance and numbers—we now count over 1000 members on our roll—our annual meetings have assumed a more prosaic character, and the presidential address must more nearly resemble that of the chairman of a large company, reviewing the year's work, forecasting the tendencies of the future, and discussing what should be our attitude towards the problems likely to confront us in the coming years.

A Heavy Toll.

Death has exacted a heavy toll from the profession since our last annual meeting, and bereft us of members we can ill afford to spare. Of these eight have given their lives for their country, while four have died in civil practice.

H. K. Bean, of Wallsend, had reached an age and professional eminence in his district which might well have warranted his resting on his oars and leaving active service to younger men. One of the first to volunteer at the outbreak of war, after arduous service in Egypt and Gallipoli, he was stricken with apoplexy and died in Egypt.

G. A. Marshall, quiet, keen, generous, beloved of all who knew him, whether patient or practitioner, had also reached a stage at which it seemed fair to claim a little ease. An enthusiastic member of the Army Medical Corps, who had already seen service in Africa, he was early at the front, was wounded at the Gallipoli landing, and subsequently developed grave anæmia, which compassed his untimely end.

J. Froude Flashman was a familiar figure within these walls. His energy, ability and scientific keenness, combined with an unusual degree of good fellowship and cheery optimism, ensured success and endeared him to the profession. By his death on active service we have lost a distinguished member of our profession, and are poorer by that loss.

Both Drs. Niven and Gibson relinquished recently established and growing practices to give their lives for their country.

One of the saddest phases of war waste is the cutting off in their youth of those whom we had marked out as destined to carry on the best traditions of our profession.

Stuart Graham, able son of an able father, had already endeared himself to his teachers and co-workers, and had given proof of unusual ability, combined with high ideals and a quiet humour, that would early have placed him in the front rank.

N. W. Broughton and R. F. Hughes, answering the call immediately on qualification, had even thus early earned the right to be looked on as among the best and most promising of our younger men.

Organization for War Purposes.

War has raised and continues to raise many knotty problems and demands grave sacrifices from all sections of the community. To this demand no class taken as a whole has responded more nobly than the medical profession. Many of our members have made heroic sacrifice of earthly goods, of future prospects, of health and even life itself, while few have not made some effort to take their share in bearing the burden of these distressful times.

As so frequently happens in an unprepared community, the burden has fallen very unequally. Some who could ill afford the sacrifice were the first to volunteer for service overseas and are still on duty at the front, while others who could well replace them are prevented from going by lack of the machinery to effect the necessary exchange. At home the brunt of service at the hospitals, the camps and the examination of recruits has been borne by comparatively few, through lack of efficient organization. These inequalities are being slowly rectified, but thanks to a bad beginning and an early failure to grasp the magnitude of the task, much still remains undone. While we cannot hope to relieve at the end of a year's service all who have gone, we must strive to do something more in that direction, and must see at any rate that the practices of those who go do not suffer in their absence.

When we come to practical measures for conserving such practices, we are met by many unexpected difficulties, and the Council has so far been unable to frame any general regulations which will adequately protect them without at the same time inflicting hardship on the general community or injustice on our own members. Where appointments to hospitals or lodges are concerned, the matter is comparatively simple, but where the right to commence practice is involved each case must be considered on its merits, and no general rule has been found to embrace all contingencies. For the loyal member no such rule is needed; for the disloyal the legislative mesh cannot be made sufficiently fine without entangling those for whom it was not meant. As regards home service, it has long been felt that the

¹ Delivered at the annual meeting of the New South Wales Branch of the British Medical Association, on March 30, 1917.

willing few have borne more than their share, and that were all ready to serve, the individual sacrifice would be comparatively light. This could easily be accomplished if all, without exception, joined the Army Medical Corps Reserve, and an energetic crusade with this end in view has been inaugurated by the Northern Suburbs Medical Association. Unfortunately, memory of the early days of disorganization have rendered many men shy of placing themselves unreservedly in the hands of the military authorities. While perhaps willing and able to-day, they feel that when the call comes, may be a year hence, unforeseen circumstances may make the sacrifice impossible. So they dread an unconditional promise.

To overcome this not unnatural reluctance the Council decided to approach the Minister to see whether a committee could not be formed similar to the District Medical Committee, created to deal with appeals under conscription, and similar to one which deals with such cases in England. The objection to a committee of this kind is that once in the Reserve the military authorities would not tolerate a committee intervening between the Commandant and any subordinate officer. The English scheme, foreseeing such trouble, arranged for all to join a special reserve, from which the committee selected as needed those to go on active service.

An attempt is now being made, through the Federal Committee of the Association, to persuade the Minister to mobilize the whole medical profession in Australia for home service, and to reconstitute the District Medical Committee. A resolution to that effect will be placed before you to-night. It is hoped that all will support this movement, or go further and ask for unconditional mobilization for service either at home or abroad, and in the meantime we trust that those who have not already done so, will join the A.M.C. Reserve. From past experience it is obvious that we must set to work to evolve some practical scheme of training and organization of the whole profession in peace time that will be ready to meet any similar crisis in the future.

The Care of the Returned Soldier.

Another problem which confronts us is the care of the returned soldier. Are we doing our full duty by him? Numerous voluntary associations, with tireless and commendable zeal, vie with one another in catering for his welfare. Are all their efforts well directed and co-ordinated; or is the work distributed through too many channels without efficient control at the fountain head? Are we right in taking no active part in these matters as an association, when we find men discharged from service with defects which could have been remedied by early and prolonged attention in skilled orthopaedic departments, or when we find no provision made for the consumptive beyond what can be offered by voluntary Red Cross workers. The Disablement Committee of the State War Council, on which we are officially represented, was formed to deal with such matters, but finding itself superseded by voluntary organizations and incapacitated by lack of funds to carry out its

recommendations for some time did little. Of late its activity has increased, and it is now doing good work, but there is still need for a central co-ordinating and directing body, with power to control the various departments.

This need for better organization of the medical side of the care of the returned soldier is being recognized in Great Britain, and should command our immediate attention. As regards orthopaedic treatment an excellent department has been established at No. 4 General Hospital within the last few months. The work is, however, nullified to a great extent owing to the neglect to provide such treatment in the early stage of the injury and on the way out to Australia. A scheme is urgently needed to supply much earlier treatment in these cases than is given at present.

The Abbreviated Course.

Among the sacrifices by the medical profession few have been greater than those of our recent graduates who, having hurried through an abbreviated course, have rushed to the front without holding any resident appointment. The practical knowledge gained before leaving was small, and will, in most cases, be little augmented on service. That they have proved efficient and admirable regimental officers we have ample evidence. But regimental surgery and medicine is not of the kind to stand them in best stead in private practice. We owe it to them that adequate post-graduate courses shall be established at our leading hospitals to make up to some extent the loss they have sustained on our behalf. Such courses would be of value not only to the returning graduate, but to those whose residence in country districts has cut them off from practical experience of more modern methods.

The attempt to compress the medical course to meet war needs has emphasized the necessity for a complete revision of the curriculum as soon as war conditions cease. In discussing such revision, it is trusted that due prominence will be given to the retention or otherwise of the systematic lecture in these days of excellent text-books, the question of endowing adequately paid chairs for full-time professors in medicine and surgery, the interchange of examiners, and to securing uniformity in standard throughout the Australian medical schools.

The Venereal Disease Problem.

During the year the Committee concerning the causes of Death and Invalidity in the Commonwealth appointed by the Department of Trade and Customs, has issued several interesting and important reports, which contain much food for reflection, both from the clinical and administrative aspect.

The report on Venereal Diseases was considered at length, and dealt with by the Medical Politics Committee of the Council, while the practical aspect of treatment and prevention formed the subject of two long and interesting discussions by the Branch. Though unanimity on such a subject was scarcely to be expected, the Committee were in cordial accord with the main provisions of the report, which provided, among others, for impersonal confidential notification, prohibition of treatment

except by legally qualified practitioners, prohibition of advertisements, imposing on infected persons statutory duty to be treated, constituting it a criminal offence knowingly to infect, provision by the State of means of diagnosis and treatment.

The Committee failed to see the need for the introduction of national insurance, with whole-time pay and prohibition to work in the infectious stage, feeling that the introduction of a bill similar to that now in force in Western Australia would meet the case, provided that the enforcement of the clauses of the bill was postponed until all the machinery for carrying them into effect was in working order. There is a regrettable tendency in all sanitary legislation to cripple and emasculate a salutary enactment by failure to provide at the same time the machinery necessary for its efficient working.

That a great change has come over the attitude of the public and medical profession towards these widespread and crippling diseases is evidenced by the passage of the West Australian Act, and more recently of similar Acts in Victoria, Tasmania, and Queensland. It is to be hoped that the remaining States will accept the offer of financial assistance from the Federal Authority, and that similar Acts will soon be in force throughout the whole of Australia.

The establishment at Royal Prince Alfred Hospital of a venereal clinic has been an interesting experiment, and one which, on the surface, seems crowned with almost too great success, the number of patients far exceeding expectation, and taxing the department to such an extent that limits had to be set on the numbers treated. A great gain has been secured in shortening the primary and secondary stages of the disease, but it is yet too early to say whether permanent results have been obtained, and whether there will be a corresponding decrease in the later manifestations.

While compulsory treatment of venereal diseases, if undertaken rationally and thoroughly, will go far towards stamping it out, prevention is a much more complex problem, one intimately interwoven with our current standards of morality. In this connexion an interesting field of speculation is opened. How much has the existence of the spirochæte and gonococcus had to answer in the past for the shaping of our moral codes, and for our keeping within their bounds. With universal spread of detailed knowledge of the physiology and pathology of sexual matters with a consequent removal of the fear of penalty for the transgression of our present social laws, will a relaxation or alteration of that code ensue, and if so, with what ultimate result to the well-being of the race?

Tuberculosis.

With the many points raised by the Committee's excellent and voluminous report on tuberculosis, limitation of time forbids me to deal, except in a most cursory manner. Careful perusal of the report is commended to all members as presenting certain novel aspects, while insisting forcibly on the old, well-known facts.

One or two points are perhaps worthy of emphasis, the relatively slight risk from bovine as compared with human sources of infection, the great danger of the careless open case and the need for his control, the unsuspectedly high incidence of the disease in middle and later life, the need for better organization in our attack on this scourge of humanity. Among other interesting points brought out is the fact that the confidential notification of closed mild cases of tubercle is advisable, not on account of the risk to the community from the presence of such individuals in their midst, but as a starting-point for the discovery of unsuspected open cases. Again, it is suggested that the humanitarian act of conferring invalid pensions on advanced cases is often against the interest of the community, through enabling such persons to remain outside an institution, and to spread disease indiscriminately. This contention is amply borne out by experience at the Anti-tuberculosis Dispensary at Royal Prince Alfred Hospital, as is the fact that careful examination of those in close contact with an open case rarely fails to find other infected individuals.

Extension of the dispensary system with systematic instruction in the early diagnosis of tubercular infection, the provision of adequate sanatorium accommodation, provision for after-care and for compulsory control of the careless open case, combined with a bureau for the co-ordination of administrative measures and for the promotion of research, would greatly reduce the ravages of this dire disease, and demand our wholehearted support. A proposal to institute a bureau of this kind was mooted at Royal Prince Alfred Hospital, but to be of value it must have some statutory power to collect the information it requires and to enforce its requests. Such a bureau as a Government Department, controlled by a keen and active officer, and backed by the willing co-operation of other Government departments and voluntary associations, would be of inestimable value. Unfortunately, experience teaches that enthusiastic activity is not the usual outcome of departmental service where the enthusiast is quickly fettered by official red-tape and soon lapses into the apathy of routine work.

Hospital Management.

A fact of general interest which may have escaped attention is that during the year a conference of the Local Government Association, comprising delegates from nearly all the municipal councils in the State, carried a motion for the creation of hospital districts, and the levying of a hospital rate. The Committee of the Association has prepared a report for submission to the Councils. The report and recommendations embody much of interest to the medical profession, and could well form the basis for an expression of opinion by our Association. More so, as such an expression is solicited by the Local Government Association, and the question of hospital support and government concerns us most nearly. A noticeable feature of the report is that the Local Government Association, composed of intelligent laymen, is at one with us in being opposed to complete nationalization of our hospitals.

The relations between our Association and the public at large during the past year have been, with one exception, most satisfactory. The Board of Health is always ready to meet us in friendly spirit, and we have to thank them and the Director-General of Public Health for many kindly acts. The recent informal conference between the Minister of Public Health and our Council is a long step towards mutual understanding, and is, I trust, but the beginning of the cordial co-operation which should exist between our Association and the various Government Departments concerned with the public health.

The Directors of the Baby Clinics have also shown a desire to confer with us as to the best methods of conducting their institutions, with the result that much good work is being done with little, if any, abuse of their philanthropic efforts.

The Health of School Children.

With the Education Department our relations have, unfortunately, not been quite so happy. Thanks to the tendency of many people to impute the lowest motives to any line of action, we have been the object of considerable misrepresentation and envenomed criticism. Such hostile criticism has also found its origin in the fact that, while we have been compelled to stress our objections to certain features in the Education Department's programme, not mainly on the score of injustice done to the profession in offering free treatment to all and sundry, but chiefly on the ground that the proposed scheme of treatment is not in the best interests of the children themselves, our critics in their anxiety to secure a system which they consider will please a section of the public, have ignored our main arguments, and seized on that of pecuniary injustice to prove our sordid motives.

Time does not permit, nor is there need for recapitulation of the arguments against the advisability, where it can be avoided, of committing the treatment of our school children to the care of the so-called Departmental specialist. But to consider for a moment the cry that our objection is only one of pocket, why, after all, should the fact that every child in the State is entitled to free secular education entitle it to free medical attendance as well. Give it by all means where parents cannot afford it. Where they can, why not complete the education of the parent by compelling him to do his duty to his offspring, instead of relieving him of the burden. A healthy body is a great desideratum, but in its pursuit do not let us lose sight of the equal need for the cultivation of a healthy mental and moral outlook regarding our responsibilities towards our offspring and fellow-men. Even in England, where the State School caters for a much lower stratum of society, a charge is made for the treatment of school defects where it is found that the parents can afford to pay.

Where lies the invidiousness of the distinction between those who are able and those unable to pay. Is not the distinction patent in our daily life, in the food we eat, the clothes we wear, in the houses in which we live, in our mode of travel? Where is the

shame in the honest threadbare coat, and where in the admission of inability to pay for special treatment?

The Profession and the Public.

That good health should be the right of all, and the prime duty of the State, is an alluring proposition, and much talk is in the air of free national medical service. The ever-increasing complexity of our methods of diagnosis and treatment throw an increasing responsibility on the individual practitioner, and necessities increasing and often prohibitive expenditure on the part of the public. How much more simple and satisfactory would it be, say the advocates of a nationalized profession, if the profession could be organized by the State so as to utilize the special abilities of each practitioner. At the first superficial glance the scheme looks tempting, but it is doomed to failure on account of one fatal objection. Convert the profession into a Government Department, remove individualism and stimulus to individual effort, and work would become to most a perfunctory routine, to be got through as best it might. Incentive to good work would be lacking, medical science would stagnate, and the standard of treatment would deteriorate. Government service in the past has failed to attract the best, and will in the future, with the exception, perhaps, of the Department of Public Health. Here we often find men of the highest type and ideals accepting a pittance far below their worth. But here it is not the routine work that appeals to these men, but the opportunity, time, and material to carry out original research, incentives that would be wanting in any other department.

Nationalization would convert the public into one huge lodge, and few regard the lodge system as better than an unsatisfactory compromise. In this connexion, having lately secured an increase in lodge rates to ensure better individual attention for its members, may it not become our duty to fix such limits to any one practitioner's list as may ensure time for adequate individual attention.

To turn to more intimate affairs, the work of the Council has proceeded smoothly and satisfactorily. Further trial of the Committee system has thoroughly established its utility and suitability for our work. The objection that members of Council obtain knowledge only of the work of their special Committee is obviated by the right of all to attend any committee, and the greater fullness of the quarterly reports. A scheme for the better representation of the country Associations, though desirable, is at present impracticable. Distance proves a barrier to regular attendance by the country resident, while delegation of his representation to individuals in the city is open to considerable objection. Meantime, we must trust to the Annual Meeting of Delegates to fulfil the function.

Our Federal Journal.

The *Journal* yearly grows in merit and importance. It has fully justified its existence as a Federal organ, and our Editor can be congratulated on having created, in the face of considerable difficulty, a medical periodical of which we may well be proud.

To its critics I would offer the reminder that the interests of the *Journal* are now Federal, not State, and that its quality must ultimately depend to a great extent on the keenness which members show in contributing worthy material to its pages.

On the scientific side, notwithstanding the unusual distractions of the times, the year's work has been of a high standard, the papers and discussions on cerebro-spinal meningitis, venereal diseases, the pathology of Friedreich's ataxy, the transmission of dengue, and the teaching of deaf mutes showing evidence of painstaking and valuable original work.

In closing this somewhat discursive review, I would like to take the opportunity of thanking all members of the Council for their cordial co-operation and help, and for the lenience they have at all times extended to my shortcomings during my year of office. More particularly would I wish to thank our Secretary and Treasurer for invaluable assistance. What their unselfish and unwearying activity means to our Branch only those brought into close touch with them can form any idea. While Presidents come—

"Like Snow upon the desert's dusty Face,
Lighting a little hour or two—are gone,"
these two men, year in and out, work steadily and unostentatiously for our common good. Long may they be spared to do so.

Lastly, I would like to congratulate the Branch on its incoming President. He brings to the Chair a fund of scientific, surgical, and business ability, combined with firmness, energy, tact, and urbanity, that bodes well for the worthy guidance of our Branch in the coming year.

Reports of Cases.

DEVELOPMENTAL CYSTS OF THE URETER AND RENAL PELVIS IN A CASE OF UNILATERAL PYELO-NEPHRITIS.¹

By S. Harry Harris, M.D., Ch.M. (Sydney),
Honorary Urologist to the Lewisham Hospital, Honorary Surgeon,
South Sydney Women's Hospital;—
and

D. A. Welsh, M.D., F.R.C.P. (Edin.),
Professor of Pathology, University of Sydney.

The specimen on which the present report is based was removed at operation by one of us (S.H.H.), and consisted of the left kidney, with about 5 cm. of ureter attached. The following are brief clinical notes of the case.

J.F.S., æt. 33 years, married, was referred for treatment on August 8, 1916, with a tentative diagnosis of left-sided pyelitis due possibly to calculus. She had been well till nine months previously. Since that time she had had more or less constant pain in the left lumbar region, though no definite attack of renal colic had occurred. There was nothing of special note in her past history.

On abdominal examination neither swelling nor definite tenderness, except in the left costo-vertebral angle, was found. The left kidney was not palpable; the lower pole of the right kidney was felt, but the organ was neither distinctly enlarged nor tender.

No abnormality was detected on vaginal examination; neither ureter was palpably enlarged.

At the time of examination there were no urinary symptoms, excepting nocturnal frequency of micturition, the patient having to rise two to four times at night. There had been no hæmaturia. The general condition was good, apart from a certain amount of wasting.

The bladder urine had a specific gravity of 1.015, was acid and contained a faint but definite cloud of albumin. It was clear macroscopically. X-ray examination of the urinary tract for stone proved negative.

The quantity of urine passed in 24 hours was 60 ounces, 65 ounces, and 67 ounces on three consecutive days.

A microscopic examination of the urine revealed numerous pus cells, but no casts, blood cells nor crystals. A pure *bacillus coli communis* infection was determined by means of films and cultures.

On cystoscopic examination a normal bladder mucosa was seen. The right ureteral meatus was normal in action and appearance. Well-coloured indigo-carmin appeared from it within 12 minutes of injection (i.e., normal). The left ureteral meatus was of the rigid golf-hole type, but was not ulcerated. The indigo-carmin test was defective from this kidney, the urine issuing from the ureter after 30 minutes being coloured a light green. A ureteral catheter was passed to the right kidney without obstruction. On the left side an obstruction was encountered and passed at a distance of 6 cm. from the bladder. The pelvic capacity of the right kidney was 8 c.cm. (i.e., normal), and the urine obtained from it was sterile on culture and free from abnormal ingredients. The pelvic capacity of the left kidney was 30 c.cm. (nearly one ounce). In two hours just under four ounces of urine were collected from this kidney for examination. The results of this examination proved to be practically identical to those of the examination of the mixed bladder urine, except that the specific gravity was 1.010, instead of 1.015.

A pyelo-ureterogram was obtained of the left kidney and ureter after the injection of 20 c.cm. of silver iodide emulsion, and a very pretty demonstration made of an early infected hydronephrosis (see Fig. I.) and stricture of the ureter (Fig. II.). Some irregular areas in the cortex were seen communicating with the renal pelvis—an appearance commonly associated with the necrosis of renal tuberculosis.

Nephrectomy was performed at the South Sydney Women's Hospital on August 22, 1916. The wound was sewn up without drainage. The wound healed *per primam* and the patient left the hospital in good condition three weeks later.

These notes and the kidney were presented at a meeting of the New South Wales Branch of the British Medical Association on September 8, 1916. At that time no microscopic examination of the organ had been made, and as the macroscopic characters suggested tuberculosis, the real condition was obscured.

Subsequent microscopic work distinguished three different abnormal conditions: (1) Mechanical pressure effects dilating the ureter, pelvis, and collecting tubules; (2) bacterial infection causing non-tuberculous pyelo-nephritis; and (3) developmental error in the form of small cysts of the ureter and renal pelvis.

(1) Mechanical Pressure Effects.

The usual hemisection (see Fig. V.) showed that the kidney substance was somewhat diminished, although the kidney measured 8.5 cm. in length and 4 cm. in breadth. The renal pelvis and ureter were moderately dilated and their walls slightly thickened. Further evidence of increased pressure was given by the fact that three of the papillæ (two at the upper pole and one at the lower pole of the kidney) were honeycombed by small cystic dilatations of the collecting tubules. A few scattered small cysts were found in other papillæ. In one of the honeycombed papillæ at the upper pole the dilatations were more advanced, and could be traced in continuity with the dilated pelvis. From this circumstance and from the further fact that all the papillary cysts appeared empty after fixation and section, no "colloid" being retained in them, we infer that their presence did not represent a partial polycystic change in the kidney of developmental origin.

¹ Based on notes read at a Meeting of the New South Wales Branch of the British Medical Association on September 8, 1916, by Dr. S. Harry Harris (see *The Medical Journal of Australia*, October 14, 1916, p. 328).

The cause of the increased pressure within the renal pelvis and ureter was not apparent within the field of examination. It was due to an incomplete obstruction to the outflow beyond that field by a stricture of the ureter, 6 cm. from the uterero-vesical orifice, as revealed by the ureterogram (see Fig. II.).

(2) Bacterial Infection of Ureter, Pelvis and Kidney.

In addition to the moderate dilatation and slight chronic thickening of the ureter and renal pelvis noted above, there were numerous nodular thickenings of the mucosa and submucosa scattered over their whole surface. On microscopic examination each nodule proved to be either a small developmental cyst, to be described later, or a focus of bacterial infection. When of bacterial origin the nodule was always small, about 1 mm. in diameter, and it was made up of an aggregation of inflammatory cells, including connective tissue cells, lymphocytes and neutrophile leucocytes. Parts of the pelvic submucosa were continuously infiltrated by a layer of such inflammatory cells, which at intervals were massed to form the small nodules visible to the naked eye.

The renal papillae were also infected, and the collecting tubules, in varying stages of dilatation, were separated often widely by inflammatory cells of connective tissue and leucocyte origin. Of the leucocytes, neutrophils formed a high proportion at certain foci, though actual suppuration, as indicated by tissue necrosis, was not observed. No microscopic evidence of tuberculosis was found in the ureter, pelvis or kidney substance.

In the honeycombed papillae, where the collecting tubules were most dilated, the most advanced inflammatory processes were also found. Otherwise the inflammation was concentrated in the pelvic margins of the papillae, and for the most part was limited to that area. But many sections through the kidney substance revealed small outlying foci of infection, which had penetrated to the perivascular tissues of the renal arches between cortex and medulla.

The cortex appeared to be healthy, apart from evidences of previous slight damage indicated by a few slender fibrous strands of chronic interstitial overgrowth spreading in from the capsule, which was slightly thickened.

Both in the renal papillae and in the pelvic mucosa the inflammatory foci contained Gram-negative bacilli, suggesting infection by an organism of the colon group. This finding is consistent with the bacteriology of the urine before operation. No Gram-positive organisms, nor any tubercle bacilli, were found in the tissues.

(3) Developmental Cysts of Ureter and Renal Pelvis.

A most remarkable feature was the presence of a number of small cystic projections from the mucous membrane of the ureter and renal pelvis. The projections were rounded, but sessile, varying from 3 mm. to 1 mm. or less in diameter. The larger were yellowish, the smaller whitish, in colour. In appearance they simulated foci of tuberculosis, although there were no definite areas of caseation, nor was the ureter thickened, as in tuberculous pyelo-nephritis.

Of the larger cystic projections (from 2 mm. to 3 mm. diameter) there were only six, and all but one were grouped within an area 2.5 mm. square, where the expanded upper end of the ureter merged into the renal pelvis (uretero-pelvic junction). Of the smaller projections (1 mm. diameter or less) it was impossible to estimate the number or to define the position, since they were indistinguishable by the naked eye from the other small elevations, due to foci of bacterial infection. Many of these smaller cystic projections appeared within the renal pelvis as well as in the ureter.

Typical specimens of the large and of the small nodules in the renal pelvis and ureter were selected for microscopic examination (Figs. III. and IV.), and were cut in serial section when their true condition began to be revealed. Many of the nodules proved to be small cysts in the submucosa of the ureter and pelvis, whence they projected into the lumen. Each cyst was lined by an epithelial layer, indistinguishable from that forming the mucous membrane of the general surface of the ureter and renal pelvis. Complete serial section of two nodules (one large and one small) did not disclose any continuity between the surface epithelium and the lining membrane of the cysts. In whatever manner they had originated, the cystic inclusions within the submucosa appeared now to be completely isolated from the general mucous membrane, although the microscopic structure of the epithelium appeared to be identical in both. The cyst contents were watery, and, after being fixed and stained, they showed a small proportion of amorphous or necrotic stainable matter, probably protein.

We are indebted to Professor J. T. Wilson, to whom we submitted specimens, both for his examination, which confirmed our observations, as above recorded, and for his help in looking through the literature for any similar record. Although our search was by no means exhaustive, we certainly have failed to find any previous reference to such a condition.

Multiple small cysts of the ureter and renal pelvis form an abnormality unique in our experience. Beyond stating that the small submucous cysts of the uretero-pelvic junction appeared to have developed from inclusions of the general mucous membrane, we can offer no explanation of their presence. It is reasonable to suggest that they represent an unusual error in development.

Description of Illustrations.

FIGURE I.

Pyelogram showing dilatation of pelvis and upper ureter; the arrows point to excavated areas (see worm-eaten areas in upper pole of kidney in Fig. V.) in the renal parenchyma, communicating with the pelvis; an appearance commonly associated with renal tuberculosis.

FIGURE II.

Ureterogram, showing lower portion of ureter; the arrow points to a stricture below the level of the pelvic brim; the ureter is dilated above the point of structure.

FIGURE III.

Smaller Cyst in Submucosa at Uretero-pelvic Junction (X 40).

The cyst is situated nearer to the inner than to the outer surface of the ureter. Its epithelial lining is indicated by a darker line, which is accidentally detached over a small area of the cyst wall. The amorphous cyst contents are shown. Slight thinning of the ureteral wall is due to pressure of the cyst.

Close to one end of the cyst there appears a different projection into the lumen. It is a solid cellular mass in the submucosa, due to bacterial infection. Its tissue has been slightly torn in preparing the section. It is a type of the inflammatory foci, which could not be distinguished by the naked eye from the smaller cysts.

FIGURE IV.

Larger Cyst in Submucosa at Uretero-pelvic Junction (X 40).

The general characters of the cyst are unaltered, though modified by its increasing size. Umbilication of the cyst wall on the inner aspect of the ureter is due to dehydration in preparing the section. There is greater thinning of the ureteral wall, owing to the greater pressure of the enlarging cyst. The epithelial lining of the cyst is mechanically approximated to the mucous membrane of the ureter, but there is no organic continuity between them.

At the annual meeting of the Linnean Society of New South Wales, Dr. H. G. Chapman, Assistant Professor of Physiology at the University of Sydney, was elected President for the session 1917-1918. The members of the Council appointed for the same period are: Mr. J. E. Carne, F.G.S.; Professor David, C.M.G., F.R.S.; Mr. W. S. Dunn; Professor Haswell, D.Sc., F.R.S.; Mr. A. H. S. Lucas, M.A., B.Sc.; and Mr. J. H. Maiden, L.S.O., F.R.S. The Council of the Society have re-appointed Dr. J. M. Petrie, Mr. E. F. Hallmann, Mr. R. J. Tilyard, and Dr. H. S. H. Wardlaw to the Linnean Macleay Fellowships for the year ending April 1, 1918.

ILLUSTRATIONS TO THE ARTICLE OF DR. S. HARRY HARRIS AND PROFESSOR D. WELSH.

Figure I.

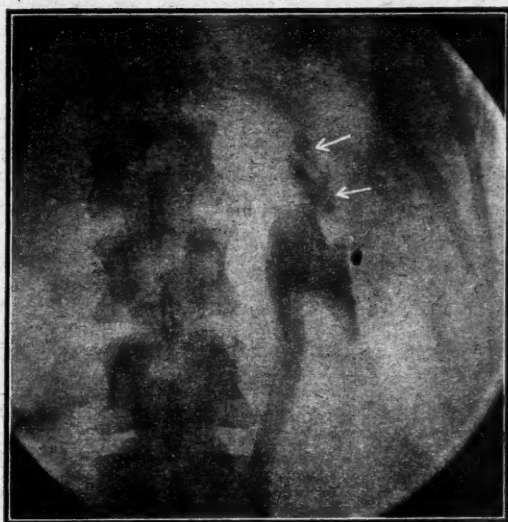


Figure II.

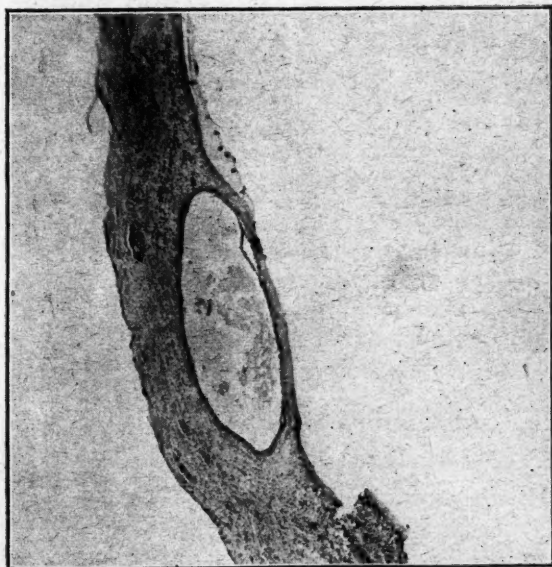


Figure III.

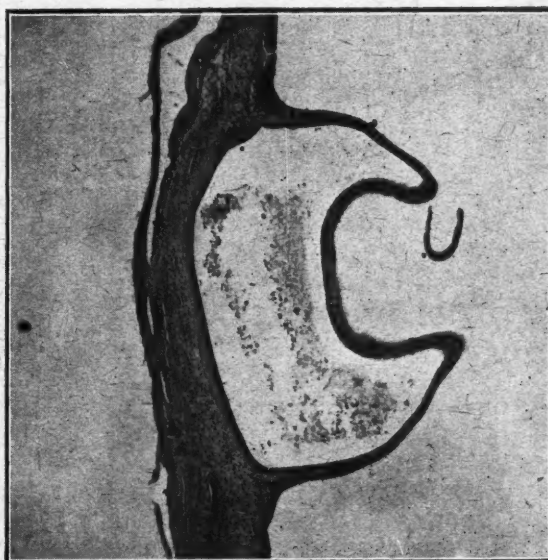
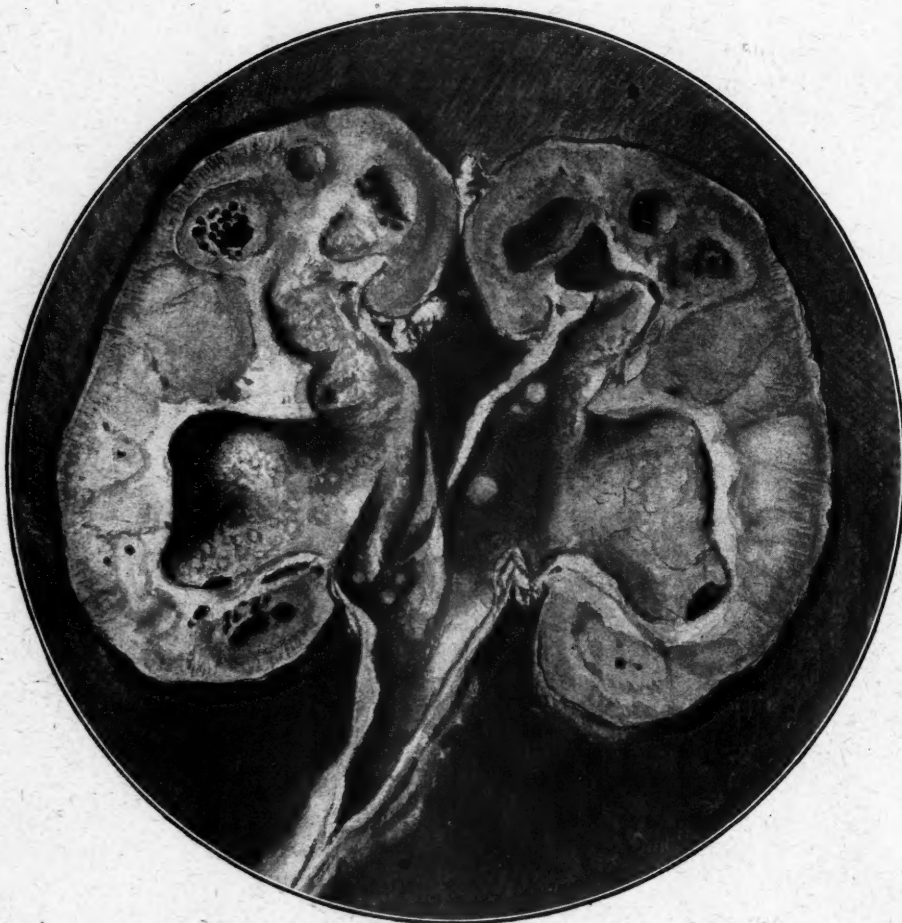


Figure IV.

ILLUSTRATION TO THE ARTICLE OF DR. S. HARRY HARRIS AND PROFESSOR D. WELSH.

Figure V.



Mesial Section of Kidney.

The Medical Journal of Australia.

SATURDAY, APRIL 7, 1917.

Compulsory Enrolment.

In the present issue we publish a summary of the discussion which took place at the Annual Meeting of the New South Wales Branch of the British Medical Association, on the motion that every medical practitioner should be enrolled as a person liable for enlistment in the Australian Army Medical Corps, and that district committees should be appointed to make selection for and recommendation for exemption from service in the Army Medical Corps. In the course of the discussion, Dr. Bligh moved, both as an amendment and later as a rider, that the liability should be for enlistment in the Australian Imperial Force as well as in the Australian Army Medical Corps. Neither the amendment nor the rider were put to the vote, and it is therefore impossible to ascertain what the opinion of each member present was, but from the remarks of those who spoke, it was abundantly clear that the suggestion was not carried as a resolution for two reasons. In the first place, some men held that since the present state of the law precluded the application of compulsion in regard to service overseas, the scheme was impracticable and a mere pious opinion. The second was that 71 men should not bind 1,000 in so important a matter. Only one speaker opposed the underlying principle, and he asserted that he would serve voluntarily, but objected to compulsion. The former objection was met by the argument used by Dr. Jamieson, to the effect that the medical profession should offer to place itself as a class apart from all others at the complete disposal of the Department of Defence, and submit to that compulsion for which the members of the profession had voted at the time of the Referendum. The authorities would certainly not refuse to consider so bold an offer, and the responsibility would be on their shoulders if they determined to refuse it. The

position of the medical profession in the war is distinct from that of any other part of the community. As long as Australian soldiers are fighting with the other British troops there must be a full complement of medical officers to tend to them when sick or wounded, and even if recruiting fails entirely, the supply of medical officers must be kept up at all costs. One speaker suggested that there had been no official notification that medical men were wanted. We have published at frequent intervals notices that the authorities were seeking as many medical practitioners as would offer themselves for service in the Australian Imperial Force. These notices were published in response to official requests, and should be taken as direct invitations from the Director-General. Given the urgent need for a large number of medical officers, and we can assure our readers that the demands of the authorities are larger than the profession appears to realize, it has become necessary to rely on something more than a voluntary system to secure the services of the men required. We would ask those who doubt the practicability of Dr. Bligh's suggestion whether it is likely that the military authority would refuse to give the proposal careful consideration in the light of the actual shortage of medical men, and in the face of a voluntary request from the body of the medical profession to be subjected to a compulsory scheme. We are not concerned with the political aspect of the conscription question, nor with the intricacies associated with the passage of a special Act of Parliament to enable it to be carried into effect. But we are concerned with the formulation of an efficient method whereby the authority may be able to secure a constant stream of suitable practitioners to serve the medical needs of the Army.

The second objection, that the few should not bind the many, has more to recommend it. But it must be remembered that, as far as New South Wales is concerned, every member of the British Medical Association had a full knowledge that the proposal of the Council was about to be discussed, and every member has had an opportunity of reading in these columns on more occasions than one that it is manifestly unfair to allow the few willing members to

bear the whole burden of the profession. Service in the Reserve is a bagatelle, compared with service overseas. In fairness to our patriotic colleagues who have already gone forward, it has become a duty of those remaining at home to support any scheme which would ensure an equitable sharing of sacrifice by the whole profession. It is improbable in the extreme that a body of seventy men would meet in a room to take part in the business of guiding the affairs of the profession in the State, and would be unanimous in the desire to sanction a scheme, while a considerable majority of the remainder would be opposed to the scheme. The contrary may be regarded as certain, namely, that the seventy men represented the medical opinion of the State. That opinion appears to be firmly in favour of compulsory enrolment for service abroad and at home.

We trust that we can go much farther in the direction of a consummation of our ideals. This matter will be dealt with by the members in the other States of Australia, and we are bold to anticipate the general opinion that the scheme put forward in a true spirit of loyalty and with much fervour by Dr. Bligh will find favour with the vast majority of medical practitioners in the Commonwealth.

THRIFT.

The question of economy in regard to foods is becoming an urgent national problem in Australia. It does not indeed appear likely that those dwelling in this fortunate continent will be faced with a deficiency of food during the present war. The Government has, however, asked every citizen to exercise control over his expenditure so that he may contribute towards the cost of the war to the Commonwealth of Australia as much as his means will permit. The prices of foods have increased greatly, and many householders must have been forced to consider how to supply a sufficient table with the same amount of money as was expended twelve or eighteen months ago.

It is well known that a diet consisting of 100 grammes of protein, 100 grammes of fat and 350 grammes of carbohydrates must be eaten daily to supply the requirements of a healthy man weighing 150 lbs., who is doing light physical work. Such a diet yields to the organism upon absorption from the intestines 92 grammes of protein, 95 grammes of fat and 340 grammes of carbohydrate, with a heat value of 2,600 kilo-calories. For the maintenance of the activities of the human frame during complete rest, 2,000 calories are needed, so that 600 calories are available as energy for the daily task.

A ration containing 3,800 calories is required for a man doing hard labour during eight hours to a condition of moderate fatigue. With such a diet useful mechanical work equivalent to 1,220,000 foot-pounds can be performed.

The food of the average man will usually be derived from both animal and vegetable sources. If the meals as eaten be made up of 8-oz. meat, 1 lb. bread, 8 oz. potatoes, 2 oz. sugar, 1 oz. butter, and 1 pint milk, the body will absorb from the food about 2,600 calories, and will receive the requisite amounts of the different food-stuffs.

These figures setting forth the quantities of the food required, are obtained from the results of experiments upon feeding men, and have been confirmed by statistical studies of the consumption of food in different countries. The quantities represent the weights of the foods eaten. The food is, however, purchased and prepared for the table. The cost of this standard diet will depend on the care with which the food is bought and on the domestic economy of the kitchen. The standard ration will not cost less than one shilling, and may cost eighteen pence in some parts of Australia, even when the food is bought cheaply and waste in the kitchen reduced to minimal proportions.

While the relative quantities of the different articles in this ration will remain the basis of all dietaries, some variation is needed to render the food appetizing. An equivalent amount of some similar food may take the place of any article in the standard diet. Meat can be replaced by eggs and cheese, bread by oatmeal and by cakes and puddings made from flour. Rice, sago, and tapioca can be substituted for potatoes. Dripping, lard and olive oil can be taken instead of butter. Other substances will be added to the diet, such as tea, jam, fruits and vegetables, which add little to the food value of the ration, though they render important aid to the nutritive processes by stimulating appetite and increasing digestion.

When the price of these articles is considered, it should be noted that vegetable foods are generally less expensive than animal foods. Even at the present price, six pounds of bread, yielding 6,300 calories, can be bought for one shilling. There is no need of any waste in using bread. A pound of meat without bone costs at least a shilling, and this weight of meat yields about 1,000 calories. Unless the meat is cooked in such a way that its fat is retained, the nutritive value falls considerably. For one shilling, 7,000 calories can be purchased retail as oatmeal, 6,300 calories as sugar, 3,500 calories as potatoes, 2,400 calories as butter, and 1,600 calories as milk.

Many careful observations have been made on the loss sustained in getting ready meals. An allowance is also made for food not eaten and left on the plate. Some investigators in Europe have found that 10% of the food purchased is not consumed. Others have computed the waste at a slightly lower figure. In Australia this waste is considerable. In a large metropolitan hospital with 500 beds, the Matron was of opinion that a loss of one-half the food bought,

was not excessive. A Judge of the Industrial Court allowed a ration of 7,500 calories, perhaps making a similar estimate as to the amount of food that would be wasted. It is in this connexion that thrift can be advantageously practised in this country. The food should be cooked and served in such a way that most of it can be eaten. A pair of scales will show how much should be cooked for a given number of persons. If food is prepared for the table at home the cost of cooking and service is small. When a meal is obtained in a restaurant a considerable payment is made for the service. Three meals made up from the standard ration will not cost more than eighteen pence in the home, but cannot be bought for less than half a crown in a restaurant.

METHODS OF EMPLOYING ETHER.

It has long been recognized that the relative safety of ether anaesthesia is profoundly influenced by the uniformity of the concentration of the vapour in the air and of the composition of the latter. Experiments undertaken by Dreser, in 1893 and later, have shown that when ether is administered with the aid of closed masks or inhalers there is a tendency for the carbon dioxide content to rise to a level no longer consistent with safety, while the oxygen content tends to become unduly reduced. The composition of the air under the mask during the inhalation of ether has been determined on but few occasions, and considerable variations have been recorded, even when the same mask or apparatus has been employed. The wide variations are associated with the so-called "closed" methods for reasons which are not far to seek. Every anaesthetist has his own particular means for supplying fresh air to the lungs of his patient during anaesthesia, and according to the degree of keeping the method a closed one, there will be more or less accumulation of carbonic acid in the apparatus and consequently in the lungs, and more or less deficiency of oxygen. The significance of these variations in the constituents of air under the mask has been dealt with recently by Drs. Pembrey and Shipway,¹ who have recorded a series of observations made in connexion with patients anaesthetized by both the "open" and "closed" methods. One set of observations was carried out on patients anaesthetized with ether applied to a Schimmelbusch mask. The ether is dropped continuously on to the shaped flannel pad, and air passes through the pad. Since the capacity of a mask is only about 250 c.cm. some air must be drawn through the pad during inspiration. They found that the concentration of carbon dioxide inside the mask varied from below 1 vol. % to close on 4 vol. %, while the oxygen in the air varied between 16 vol. % and 19 vol. %. In other words, the amount of carbon dioxide was not excessive. At the end of expiration the concentration in the air within the mask will approximate the concentration in the alveolar air, and the stimulation of the respiratory centre will be sufficient, but no more. At the end of inspiration the oxygen and carbon dioxide concentrations will be the same as those of

the outside air. The concentration of the ether vapour is not necessarily uniform by this partly open method, since the supply of anaesthetic is by drops, and intermittent. When ether is administered by the "warm" method, that is when the ether is volatilized by a known volume of air passing through liquid ether at a given temperature, the variation in the tension is reduced to a minimum, and a skilled anaesthetist can obtain the optimum tension of ether in the blood and tissues at will. The carbon dioxide content during anaesthesia induced by the warm method is kept within normal limits, and there is never any tendency to an oxygen deficiency. When ether is given by the "closed" method, safety is only attained by the skill of the anaesthetist in modifying the method until it becomes practically an open one. Drs. Pembrey and Shipway have found the carbon dioxide concentration rise to as high as 6.36 vol. %, while the oxygen concentration fell as low as 10.7 vol. %. When these conditions obtain there is undoubtedly grave danger to the patient. The excess of carbon dioxide stimulates the respiratory centre and induces deeper breathing, which means an additional amount of ether vapour inhaled and extra work thrown on the nervous, muscular and vascular systems. Simultaneously, the deficiency of oxygen produces anaesthesia and may accentuate the effect of the ether vapour. These observations give us the clue to safety in ether administration and reveal the fallacy of attempting to carry out a "closed" method.

THE HOSPITAL DIFFICULTY IN TASMANIA.

The Council of the Tasmanian Branch of the British Medical Association, as has been reported on page 192 of *The Medical Journal of Australia* of March 3, 1917, communicated with the Premier of the State, that unless an assurance were given that persons in affluence would be excluded from the State-aided hospitals, the honorary medical officers would be forced to tender their resignations. The letter conveying this message bore the date of February 15, 1917. No reply to this letter was received until March 17, when the Premier wrote to the effect that he had discussed the matter with his colleagues in full Cabinet meeting. No decision had been arrived at, and he informed the Council that the matter needed careful consideration. "Pending such consideration, it is not intended to make any alterations in existing conditions." The Council thereupon determined not to procrastinate further, and called upon all honorary medical officers on the staffs of the State-aided hospitals in Tasmania to forward their resignations to the Honorary Secretary of the Branch by March 26, 1917. Every practitioner holding these positions complied with the request, and the Honorary Secretary was able to forward to the Secretaries of the hospitals the resignations of all the honorary medical officers. The resignations will take effect on April 14, 1917.

It has been reported in the daily press that Dr. E. P. Cockey, of Goomalling, Western Australia, met with a fatal accident on March 31, 1917. Dr. Cockey was driving his car with two passengers on board, and ran into a train at a level crossing. The car was capsized and wrecked, but the three occupants were apparently uninjured. It is stated that Dr. Cockey spoke to various people, and walked some distance when he suddenly became unconscious. He was placed in the train, but died before it reached Goomalling.

We have been compelled, on account of want of space, to defer the publication of the text of the *Veneral Diseases Act*, Victoria, 1916, until next week.

¹ *Proceedings of the Royal Society of Medicine*, December, 1916.

Abstracts from Current Medical Literature.

PATHOLOGY.

(106) Secondary Infection in Pulmonary Tuberculosis.

F. Hall and S. C. Harvey point out that there are two methods of studying secondary pyogenic infection in patients suffering from pulmonary tuberculosis (*Journ. Med. Research*, January, 1917). The two methods are (1) the examination of the microbic flora of the sputum, with an investigation of the serological reactions of the patient against the germs detected, and (2) the search in the blood for a bacteriæmia having its source in the secondary pulmonary lesion. In this communication the authors deal with the presence of bacteria in the bloodstream. They have been unable to confirm the results of previous investigators who have found micro-organisms in the blood from a large percentage of patients subject to pulmonary tuberculosis. They have made fifty-two blood cultures from forty-three persons suffering from pulmonary tuberculosis. In two cases only were cultures obtained. Twenty-eight examinations were made in the febrile period. The first thirty-nine examinations were made by placing the blood in neutral calcium carbonate bouillon. Cultures were incubated for ten days, while subcultures on blood agar tubes, and the microscopic study of smears, were made from time to time. The next ten examinations were made with a somewhat different technique to make use of the media employed by Avery and Lyall. Five examinations were made with a bouillon containing dextrose. A special arrangement of a syphoned flask was used to permit of the repeated removal of portion of the contents of the flask without danger of infection of the flask from the air. An account is given of the forty-three patients to demonstrate that the series was representative. Forty of the patients had "open" lesions. Twenty-eight had advanced disease. At the time of writing the paper, 25 patients were dead, 11 were in an unsatisfactory state, and 6 were doing well. The condition of one was not known. The authors conclude that severe pulmonary tuberculosis, even with secondary infection, is rarely accompanied by bacteriæmia.

S. C. Harvey (*Journ. Med. Research*, January, 1917) states that the proof of the existence of a secondary infection in the tuberculous process must depend upon the isolation from the sputum of the bacteria responsible for the secondary infection. Masses of sputum are freed from the organisms of contamination in the mouth, and examined by culture methods. The

author has devised an apparatus for this purpose. The patient washes the mouth with a suspension of *Bacillus bulgaricus*. The presence of this organism in the cultures provides a proof that the sputum has not been freed from organisms entering the sputum during its passage through the mouth. The sputum is washed in a continuous stream of sterile salt solution until nothing remains but a small fragment of fibrinous mesh. A small part of the fibrinous mesh is stained for acid-fast bacilli. The presence of acid-fast organisms identifies the fibrinous mesh with the tuberculous lesion. Cultures are made from the fragment and examined in such a way as to identify the organisms. It has been found that it is necessary to divide the mass of sputum into several portions, which are washed for different intervals of time to obtain sufficient evidence to recognize the source of the colonies. Thus, in one example, after washing the sputum for one hour, abundant colonies of *Staphylococcus aureus* were noted. On washing thirty minutes more a few colonies of streptococci were found. On washing still longer, streptococci alone were found. In another example a few colonies were found after washing one hour. On continuing the washing for three hours, the same number of colonies were obtained. This observation is regarded as indicating an association of the organism with the tuberculous lesion. In a third case the colonies of the organisms disappeared on washing for a slightly longer period. The association of the organism with the tuberculous process is considered doubtful. The author relies on repeated examinations of the sputum of the same patient over a period of months for the demonstration of the existence of secondary infection due to a particular germ. The author had hoped to complete the proof of the presence of the secondary infection by a study of the immune reaction of the patient against the organism isolated. As he has not been able to do this, he has published his findings only as examples of bacilli found in relation with tuberculous lesions. As recorded by other authors, *Streptococcus non-hæmolyticus* is the most commonly observed pyogenic organism.

(107) Ascending Infection of the Urinary Tract.

D. N. Elsendrath and G. T. Schultz have studied the path of involvement in ascending infections of the urinary system in dogs and rabbits (*Journ. Med. Research*, January, 1917). The study was made by introducing cultures of microbes into the bladder, with every precaution against injury of the bladder or ureters. At varying intervals of time the animals were killed. Cultures were made from the heart, kidneys and bladder, while serial sections were cut through the whole of the tissues from the kidneys to the bladder. The material was imbedded in paraffin before section. The sections were made parallel to the ureter,

so that each section passed from the bladder to the kidney. Two series of experiments were made. In the first series, five rabbits and eight dogs were injected with *B. coli*, three rabbits and four dogs with *S. aureus*, and three rabbits and four dogs with *B. proteus*. Eleven dogs and twelve rabbits were used to form a control series in which no germs were placed in the bladder. In the second series female dogs were used. Three were injected with *B. coli*, four with *aureus*, and four with *B. proteus*. The observations on the anatomy of the animals have demonstrated the existence of a network of lymphatics extending from the bladder along the ureters to the renal pelvis. The lymphatics of the pelvis of the kidney communicate with those of the parenchyma of the kidney. On the cortex of the kidney the lymphatics continue into the peri-renal tissue. The experiments showed that germs present in the bladder could pass by these lymphatics into the kidneys. The degree of involvement depends on the virulence of the organisms and the susceptibility of the animal. In five out of 39 experiments the bacilli had not spread up the ureters. The infection spreads from the pelvis of the kidney to the kidney along the intertubular and perivascular lymphatics. A connexion with the lymphatics of the genital organs was noted in the female dogs.

(108) Respiration in Persons with Pneumothorax.

J. H. Means and G. M. Balbioni have studied the respiration in four persons in whom pneumothorax had been produced for pulmonary disease, and in one case of spontaneous pneumothorax (*Journ. Exper. Medicine*, December, 1916). The patients were four women and one man. They were examined by means of Benedict's unit apparatus. Measurements were made of the output of carbon dioxide, intake of oxygen, amount of the ventilation per minute and rate of respiration. The basal metabolism was calculated. In three subjects the alveolar tension of carbon dioxide was estimated. The sensitivity of the respiratory centre to carbon dioxide was carefully tested. The results show that all the factors of respiration and gaseous metabolism are normal in persons with collapsed lungs. The reaction to carbon dioxide is similar to that of healthy persons up to the point when the ventilation is trebled. The authors conclude that there is a large margin of safety in the lungs, and that one lung is as efficient as two, except when the performance of work calls for more than a threefold increase in the normal ventilation.

PÆDIATRICS.

(109) Banti's Disease in Children.

Graham (*Arch. of Pediatrics*, November, 1916) reports a case of Banti's dis-

case in a child, aged 7 years, under observation for about nine months. His description of the disease and its treatment is as follows:—Splenic anaemia is essentially a chronic disease, the first stage of which usually lasts for about five years, during which time the symptoms are mild; after this period, for two or three years, they gradually become more severe, until finally the syndrome of Banti's disease, i.e., hepatic cirrhosis, ascites and jaundice, develops, and the case rapidly progresses to a fatal termination. Treated medicinally, splenic anaemia is almost invariably fatal, no cures having been reported, though in some cases there has been a slight temporary improvement. Under surgical treatment the prognosis is rather more favourable than otherwise, the outlook depending upon the duration of the disease at the time the spleen is removed. If done early splenectomy is attended by slight mortality, and in uncomplicated cases a cure may be expected; but when the disease is complicated by other affections of a chronic infectious nature, the value of the operation is questionable. In children, operation is even more advantageous than in adults, and complete recovery is the rule with the rapid disappearance of all symptoms. After operation the blood picture in the majority of cases more or less approaches normal, but in a few cases it may vary greatly, so that five years may elapse before the differential count becomes normal. When Banti's syndrome becomes well established, the prognosis is most unfavourable, even though splenectomy be performed, for the vital organs have become the seat of degenerative changes, and the liver is cirrhotic. In some cases removal of the spleen will arrest the development of the disease, but will not cause retrogression of the hepatic cirrhosis. Recovery has been reported in a few instances in which the spleen was removed, while the cirrhosis was very slight, but these cases are exceptional. As a rule the mortality is very high when splenectomy is done at this stage, and the results are unsatisfactory. Medical treatment consists in giving iron and arsenic for the anaemia, but these do not affect the underlying cause of the disease. Salvarsan and X-ray treatment act similarly. Surgical treatment consists in performing splenectomy. This operation removes an organ in which an infectious or toxic process is going on, causing fibrotic enlargement and the formation of a splenic haemolysis. After operation, if iron is supplied in abundance, polycythæmia will result in many cases. In cases where the hæmoglobin is below 30% and the red cells below 2 million, splenectomy is both useless and dangerous. The operation should, as a rule, be attempted only when there is no cedema, no parenchymatous nephritis, and no serious change in the liver, and while the patient is still able to go about. In severe cases blood transfusion, if done shortly before the splenectomy, seems to increase the ability of the child to withstand the post-operative shock.

In 25% of these cases of splenectomy there is afterward pain in the long bones, due probably to hyperplasia of the marrow. After operation, too, there is always danger, especially in the first two weeks, of gastro-intestinal hæmorrhages, or of secondary infection owing to lowered power of resistance. In the report of the author's case, there is a full account of the several blood examinations and of the child's condition from time to time. The illness had lasted about six years. An operation had not been performed.

(110) Heart Disease in Infancy and Childhood.

Anatomically the infant's heart differs from the adult's in that it is comparatively large and heavy, with massive walls and small cavity, the muscle being equally thick on the right and left sides. Any interference with normal general development may result in disturbances of the general circulation and indirectly of the heart itself. Local changes in the chest wall may markedly affect cardiac development. In the embryo the right side of the heart is larger than the left, but with the change of circulation at birth, and with the beginning of regular muscular activity there is a change in the relative sizes on the two sides. After the first year of life the left side predominates. For practical purposes, Goodman (*Arch. of Pediatrics*, December, 1916) classifies cases of heart disease in infancy and childhood into (a) congenital and acquired; (b) organic and functional; (c) acute and chronic. He groups the congenital cases into (1) those causing a thrill, cyanosis, enlargement and a murmur; (2) those with enlargement, but without cyanosis; (3) those without cyanosis or enlargement. Group I. includes cases of pulmonary stenosis, but the patients die within a few days of birth, unless some other compensating change be present. In this group, if the murmur heard over the heart area is transmitted from right to left, a condition of open ventricle is present; if upward into the vessel of the neck, open *ductus arteriosus*. Cyanosis is due to pulmonary stenosis. In Group II., if the murmur is confined to the heart area, there is an open ventricular septum; if it extends into the neck, an open *ductus arteriosus*. In Group II. the usual complication is an open auricular septum, or an open *ductus arteriosus*, as the case may be. Functional murmurs occur usually in the course of the infectious diseases, and especially so during influenza and diphtheria, due to myocardial changes, with irregular muscular contractions pulling on the *chordæ tendinæ* at different intervals. The murmurs gradually disappear during convalescence. Organic heart disease represents by far the largest group of heart disease met with in hospital, and the cause is always the same, viz., repeated attacks of rheumatism either muscular or articular in character.

Treatment in the congenital cases consists mainly in protecting the child from the danger of exposure to infection. In the functional cases the author advocates early stimulation in the course of the infectious diseases, thus improving the tonic and contractility of the myocardium so that it may withstand any extra strain due to the presence of an unusual amount of unneutralized toxin. Treatment of the organic cases should be essentially prophylactic, and resolves itself into early and intensive medication with the salicylates, regulation of the diet and clothing, rest in bed with each rheumatic attack, however mild, and attention to the general health. Failure of compensation must be treated on the usual lines.

(111) Diphtheria Carriers.

The majority of the methods employed in the attempt to render "carriers" free of diphtheria bacilli have proved of little use. These include swabbing with various antiseptic solutions, use of vaccines, etc. Where the throat has been the seat of the trouble tonsillectomy would undoubtedly clear up the situation; but this treatment is not always possible or advisable. Bell (*Arch. of Pediatrics*, November, 1916) for home use advises the "kaolin treatment," in which the dry, powdered substance is blown into the nose every two hours during the day, and for the throat the patient is instructed to swallow half a drachm of the powder every hour. The average time for cure in eight reported cases was six days. A much more satisfactory method, both for hospital and private use is the treatment of throat and nose with fresh broth cultures of the *staphylococcus pyogenes aureus*; but the author insists on the adoption of his own never-failing technique. First an active organism must be isolated in pure culture. Each night from this stock culture a slant of plain agar is inoculated and incubated for twelve hours. At the end of this time two loopfuls of the twelve-hour growth are transferred to a five ounce mixture of broth, composed of salt peptone and Liebig's beef extract and water, previously bottled and sterilized. This mixture is only used for twelve hours, when a fresh mixture, made as above, is employed. If the twelve hours' growth is not luxuriant, the broth culture may be incubated for twelve hours before using. The treatment is not applied unless the persons are free from clinical manifestations. The throat is carefully swabbed, round the tonsils and into the crypts, daily. Then the tonsils are sprayed every two to three hours, the spray being kept at a temperature of 35.6° C. Where much congestion is encountered in the nasal mucosa of the nasal carrier a solution of 1½% to 3% cocaine is first applied, and the nose then swabbed as above, the spray being used afterwards every two to three hours. All the author's cases became negative by this method in 24 hours, but only when a dependable broth culture was used.

THE ZEMSTWOS.

From the introductory remarks published in our issue last week, it will be gathered that the administration of a certain amount of local government has been handed over to statutory bodies in various parts of Russia. The official position and functions of these local government departments, or Zemstvos, as they appear on paper, may be described in the following manner. The Russian Empire is divided into provinces (the Russian word actually means governments), and these are sub-divided into districts. With the exception of those areas lying around the Ural Mountains, the whole of European Russia was granted, in the year 1864, a limited amount of local government. Up to this time a feudal system had been in force, and the Zemstvo system was supposed to replace it. The Zemstvo institutions consist in local assemblies, which have to meet once a year regularly, and which hold one or two extraordinary meetings, and their executive bodies, called *Uprava*. The district Zemstvo assemblies, or parliaments, are elective bodies, the members being elected by the community for a period of three years. These assemblies include a "Peasants' Assembly," a "Nobles' Assembly," and a "City Assembly." The third consists of representatives of the community other than the peasantry and the nobles. In electing the members of the "Nobles" and the "City" Assemblies the large landowners have a direct vote, while the smaller land-holders have indirect voting powers. The executives of the various assemblies consist of from four to six members, who are appointed by the assemblies themselves. The members of the assemblies also elect out of their own number members to sit in the Provincial Assemblies. On the other hand, the Provincial Assemblies include a large number of *ex officio* members who have full voting rights. For example, in one Provincial Zemstvo Assembly having 60 elected members, there are 25 *ex officio* members, representative of the various State Departments, and of the Church. The Provincial Assemblies elect their own executive bodies, or standing boards, of six members with a chairman.

The Zemstvos have certain duties to perform for the military and civil governmental departments. Their functions comprise the looking after the local interests and needs. Among the needs are included the State schools, the construction of roads, fire insurance, the country postal arrangements, the poor law, social hygiene, medical and veterinary assistance, agricultural and other industrial arrangements, etc. The Assemblies have the right of initiative, and are permitted to determine within certain definite limitations the means to carry their desires into effect. It is, however, pointed out that all persons elected to any official position have to receive confirmation of the appointments from the Imperial Government, and that all resolutions of the Assemblies have to be sanctioned at headquarters, in regard both to their legality and also to their utility. In addition, the right to increase and to levy taxes is only granted under exceptional circumstances. When the powers and duties of a Zemstvo in regard to any particular matter is not defined by law, the Provincial Assembly is required to decide the point. The duties of the Provincial Zemstvo Assemblies include the care of institutions of public utility, of which all the districts within the province take advantage. Among these are the schools for nurses and midwives, laboratories for the supply of vaccines and antitoxic sera for domestic animals, school teachers' seminaries, public hospitals, asylums for the insane, maternity institutions, and orphan asylums. They have control over undertakings which extend their activities beyond the area of a single district, such as compulsory fire insurance boards for farms, pensions boards for the employees of the Zemstvos, and certain extensive measures necessary for the control of epidemics. Further, the Provincial Zemstvo may be called upon to undertake action in regard to matters requiring uniformity throughout the country. As an example of this may be cited the keeping of statistics, the registration of patients, the carrying out of compulsory sanitary regulations, the inspection of industrial plant, the regulation of markets, and the control of emigration. Closely associated with this is the duty to endeavour to

introduce uniformity in the methods adopted by the various District Zemstvos, and in this connexion the Provincial Zemstvo may issue periodical reports and publish medical and other journals. In the last place, the Provincial Zemstvo has obtained increased powers since 1890, in having the right to subsidize the undertakings of the District Zemstvos when the cost is too heavy for them to bear, or when the District Zemstvos have not introduced desirable measures because the community has not yet realized the utility of the same. To the former class belong the building of schools, the erection of isolation departments of public hospitals, and of disinfectors, and the construction of drinking-water fountains. To the latter class belong measures for improving agriculture and horticulture, lectures on hygiene, and so forth. The blind and deaf institutions, the University clinics, various schools, scientific societies, State afforestation schemes, and a few other undertakings receive subsidies from these Provincial Zemstvo Assemblies.

First-aid, the erection of hospitals, the provision of nurses and midwives, the distribution of medicines, vaccination, etc., all belong to the duties of the District Zemstvos. In all matters of public health and of medical importance, the advice of the District Medical Board has to be sought. There is no obligation to follow this advice, but it is pointed out that guidance obtained in this manner in the past has proved itself to be of value, and has exercised a profound influence on the development of the medical profession.

Since these Assemblies have such varied duties, it has become necessary to organize special departments. Each department is controlled by a special committee, with an expert as chairman.

The foregoing description of the constitution of the various bodies named may be regarded as corresponding both to the official programme and to practice. The description given in regard to powers, duties and organization represents the aspect which the Imperial Government presented to the world, and which was recorded in official returns. It will have been noted that the activity of each body was limited by a control at headquarters. How far that control interfered with the proper conduct of the functions of the Zemstvos will be indicated in the next contribution.

British Medical Association News.

ANNUAL MEETING.

The annual meeting of the New South Wales Branch was held at the B.M.A. Building, 30-34 Elizabeth-street, Sydney, on March 30, 1917, Dr. Sinclair Gillies, the President, in the chair.

The Honorary Secretary moved that the report, as printed, be taken as read and received. This motion was seconded by Dr. Sydney Jamieson and was carried.

Annual Report of Council.

The Council has the honour to present the following Report upon the work of the Branch for the year ended March 30, 1917:—

Membership.—The membership is now 1038, as against 974 at the time of last year's Report. The losses have been as follows, *viz.*: By resignation, 4; by removal out of the area of the Branch, 14; by non-payment of subscription, 5; not including a number of members absent on military service, for the continuance of whose membership financial arrangements have been temporarily made; by death, 9. The losses by death were as follows, *viz.*: Dr. H. K. Bean, Dr. J. Lang Niven, Dr. G. A. Marshall, Dr. E. A. Marsden, Dr. B. D. Gibson, Dr. J. F. Flashman, Dr. W. P. Bassett, Dr. C. B. Tyrie, Dr. S. M. Graham. Of these, Dr. H. K. Bean, Dr. J. Lang Niven, Dr. G. A. Marshall and Dr. J. F. Flashman died of illness incurred on active military service. Dr. B. D. Gibson was drowned in Egypt while on

active service, and Dr. S. M. Graham died in France of wounds received on active service.

Meetings.—Eleven Ordinary Meetings, including the Annual Meeting, with an average attendance of 39 members, were held. There were also eight Clinical Evenings, with an average attendance of 33. At the Ordinary Meetings and Clinical Evenings the business included 45 papers, 25 reports of cases, numerous exhibits and three lantern demonstrations, while one evening was devoted to a demonstration of the methods employed in the education of the deaf by Mr. H. Earlam, Superintendent of the New South Wales Institute for the Deaf and Dumb and the Blind.

Representation.—The Branch was represented as follows:—

- (a) Council, British Medical Association: Dr. C. J. Martin (Lister Institute).
- (b) Representative Body: Dr. Clarence Read.
- (c) Federal Committee of the British Medical Association in Australia: Dr. G. H. Abbott and Dr. David Thomas.
- (d) Australasian Medical Publishing Company: Dr. W. H. Crago, Dr. F. P. Sandes, Dr. R. H. Todd.
- (e) Council of the New South Wales Bush Nursing Association: Dr. Sinclair Gillies.
- (f) State Medical War Committee (Disablement Sub-Committee of the State War Council): Dr. George Armstrong, Dr. W. H. Crago, Dr. R. H. Todd.
- (g) District Medical Committee (War Service Regulations, 1916, War Precautions Act, 1914-1916): Dr. Sinclair Gillies, Dr. R. H. Todd.

Council.—The attendance of members of the Council and of the Standing Committees and Sub-Committees of the Council at meetings is shown as follows:—

Council (Meetings held, 9)—

Dr. Sinclair Gillies (President)	9
*Dr. R. Gordon Craig (Vice-President)	6
Dr. G. H. Abbott	6
Dr. George Armstrong (Ex-President)	5
Dr. Fourness Barrington	8
Dr. E. H. Binney	9
*Dr. C. B. Blackburn	3
Dr. A. J. Brady	8
Dr. W. H. Crago (Hon. Treasurer, Acting Hon. Librarian during the absence of Dr. J. Adam Dick)	6
Dr. Andrew Davidson	9
*Dr. J. Adam Dick (Hon. Librarian)	0
*Dr. Sydney Jamieson	5
Dr. T. W. Lipscomb	9
Dr. W. F. Litchfield	9
Dr. A. A. Palmer	7
Dr. F. Antill Pockley	6
Dr. F. P. Sandes	9
*Dr. R. Scot-Skirving	0
*Dr. David Thomas	4
Dr. R. H. Todd (Hon. Secretary)	8

Executive and Finance Committee (Meetings held, 12)—

President (Dr. Sinclair Gillies), Chairman	9
Vice-President (Dr. R. Gordon Craig)	9
Ex-President (Dr. George Armstrong)	9
Hon. Treasurer and Premises Attorney (Dr. W. H. Crago)	10
Hon. Secretary (Dr. R. H. Todd)	12
Hon. Librarian (Dr. J. Adam Dick)	0
Dr. G. H. Abbott	7
Dr. Sydney Jamieson	6
Dr. David Thomas	8

Ethics Committee (Meetings held, 11)—

President	8
Vice-President	1
Hon. Treasurer	6
Hon. Secretary	9
Dr. Fourness Barrington (Chairman)	11
Dr. E. H. Binney	10
Dr. C. B. Blackburn	4
Dr. A. J. Brady	10
Dr. A. A. Palmer (Hon. Secretary)	10

* Absent for all or part of the year on active service.

Organization and Science Committee (Meetings held, 12)—

President	3
Vice-President	2
Hon. Treasurer	4
Hon. Secretary	10
Hon. Medical Secretary, Dr. G. H. Abbott (Chairman)	4
Dr. E. H. Binney	11
Dr. A. Davidson	12
Dr. W. F. Litchfield	12

Medical Politics Committee (Meetings held, 14)—

President	13
Vice-President	6
Hon. Treasurer	9
Hon. Secretary	11
Dr. G. Armstrong	9
Dr. T. W. Lipscomb	12
Dr. A. A. Palmer	7
Dr. F. Antill Pockley (Chairman)	11
Dr. F. P. Sandes (Hon. Secretary)	13

Medical Journal Sub-Committee (Executive and Finance Committee) (Meetings held, 11)—

Gr. George Armstrong	9
Dr. W. H. Crago	8
Dr. Sinclair Gillies	8
Dr. F. P. Sandes	3
Dr. R. H. Todd	10

The Representatives of the Local Associations appointed on the invitation of the Council to attend the regular Quarterly Meetings of the Council were as follows: Dr. E. A. R. Bligh (Northern Suburbs), Dr. G. H. Walton Smith (Eastern Suburbs), Dr. A. Maitland Gledden (City), Dr. E. C. Hall (Central Western), Dr. G. A. Buchanan (Central Southern), Dr. H. Ritchie (Northern District), Dr. H. Busby (Western), Dr. F. C. S. Shaw (Southern District), Dr. R. W. Young (South Sydney), Dr. S. S. Shirlow (Balmmain District), Dr. W. J. White (Illawarra Suburbs), Dr. Harold Browne (Western Suburbs).

B.M.A. Building.—Dr. W. H. Crago, as Attorney of the Branch for the management of the B.M.A. Building, has kindly continued his services with the advice of the Executive and Finance Committee.

The Library.—The care of the Library has continued in the hands of Miss A. L. Whitfield, under the direction of Dr. W. H. Crago, acting for Dr. J. Adam Dick. Several gifts of valuable books have been received from members, including Dr. R. Worrall, Dr. S. T. Knaggs and Sir Phillip Sydney Jones.

Affiliated Local Associations of Members.—The activity of the Local Associations of Members has been well maintained during the year, despite the absence on military service of a large number of active members. The following is a list of the Affiliated Local Associations of Members and their Hon. Secretaries:—

Northern Suburbs: Dr. E. A. R. Bligh, North Sydney.
 Eastern Suburbs: Dr. J. C. Hughes, Centennial Park.
 Western Suburbs: Dr. H. B. Oxenham, Leichhardt (acting for Dr. J. F. Walton).
 South Sydney: Dr. J. Hoets, Glebe.
 City: Dr. C. E. Corlette, College Street, Sydney.
 Illawarra Suburbs: Dr. W. J. Binns, Kogarah.
 Balmmain District: Dr. W. Brodie Grant, Rozelle.
 Border: Dr. R. A. Robertson, Albury.
 Western: Dr. L. W. Roberts, Orange.
 Central Western: Dr. E. C. Hall, Parramatta.
 North-Eastern: Dr. R. V. Graham, Lismore.
 Northern District: Dr. E. W. Buckley, Tamworth.
 Eastern District: Dr. F. O. Stokes, Taree.
 Central Northern: Dr. H. G. Allen, Newcastle.
 Southern District: Dr. W. W. Martin, Wagga Wagga.
 South-Eastern: Dr. W. L. Kirkwood, Wollongong.
 Central Southern: Dr. G. A. Buchanan, Goulburn.

Annual Meeting of the Delegates of the Local Associations with the Council.—The fifth Annual Meeting of the Delegates of the Affiliated Local Associations of Members with the

Council was held on October 6, 1916, at the B.M.A. Library, Sydney. The Delegates were as follows:—

- Dr. L. W. Roberts (Western), acting for Dr. H. Busby.
- Dr. Harold Browne (Western Suburbs), acting for Dr. C. H. E. Lawes.
- Dr. E. A. R. Bligh (Northern Suburbs).
- Dr. G. A. Buchanan (Central Southern).
- Dr. A. J. Opie (Northern-Eastern), acting for Dr. T. Henry.
- Dr. E. C. Hall (Central Western).
- Dr. A. Maitland Gledden (City).
- Dr. W. C. McClelland (South Sydney).
- Dr. J. C. Hughes (Eastern Suburbs), acting for Dr. P. Walton Smith.
- Dr. F. C. S. Shaw (Southern District).
- Dr. W. J. White (Illawarra Suburbs).
- Dr. H. J. Ritchie (Northern District).
- Dr. H. G. Allen (Central Northern).

The proceedings of the meeting were published in *The Medical Journal of Australia*, 1916, Vol. II., page 351.

Contract Practice.—

(a) Friendly Society Lodge Practice.—The approved Common Form of Agreement Between Medical Officers and Friendly Society Lodges has continued to work satisfactorily. During the year the Lodges in the following places, which for the two previous years received their medical attendance independently of the Association, accepted the approved agreement, *vis.*: Maitland, Illawarra Suburbs, Wellington, Goulburn, Burwood, Mudgee, Mullimbimby.

(b) Attendance on Railway Construction Works Employees.—A new system of providing medical attendance for the employees in railway construction works has been introduced by the Public Works Department by the establishment of a "Public Works Medical Fund." Under the system a weekly contribution of sixpence, supplemented by a Government contribution of threepence, is paid to a fund administered in Sydney by four Trustees, two of whom are appointed by the Railway Workers and General Labourers' Association, one by the Public Works Department, and one by Messrs. Norton Griffiths & Co. Arrangements are made with the medical practitioners in the locality where the work is being done; the employees have free choice of doctor, and the doctors are paid their ordinary fees per visit. On the whole the plan appears to work more satisfactorily than schemes hitherto devised for the purpose.

The Medical Journal of Australia.—In common with many other newspaper enterprises, *The Medical Journal of Australia* has had to contend with many war-time difficulties, and the Directors are to be congratulated on the way in which these have been met. The *Journal* has continued to grow in favour with the members, and has successfully fulfilled the requirements of the Branch as the official organ of the Association of Australia. The Editor has been kind enough to attend the meetings of the Medical Politics Committee and the Quarterly and other Meetings of the Council, and has thus been closely in touch with the work of the Association in this State.

Medical Politics.—

(a) Departmental Medical Treatment of State School Children.—Much anxiety has been felt owing to the persistence of the Education Department in its proposals for entrusting the treatment of the defective school children to salaried departmental officers. A clinic for the general treatment of school children was opened in Sydney on December 18, 1916, but it is not known to what extent it has been utilized. The Minister, the Hon. A. James, M.L.A., was kind enough to allow himself to be approached by representatives of the Council, and heard their suggestions for a more acceptable and effective way of meeting the needs of the children for systematized medical attention. It is hoped that, in the interest of the children, a broad view of the situation will be taken, and that facilities will be afforded for the children, at all events in the metropolis, to have the benefit of the special departments of the public hospitals for the removal of their defects.

(b) Free Medical Attendance in the Federal Territory.—The attention of the Council has been given to a novel procedure, which it is alleged has gradually established

itself, of providing free medical attendance by a whole-time departmental officer for all and sundry who are on business in any capacity within the Federal Territory from the Administrator downwards. This may be a temporary expedient, necessitated by the fact that existing conditions do not admit of private practitioners residing in the Territory; or it may be the foreshadowing of a definite policy for the permanent prohibition of private practice within the Territory. Communications have passed between the Council and the Departments concerned, but it is not possible at the present time to do more than note the position of affairs.

Legislation.—No Acts of Parliament, either Commonwealth or State, directly affecting the medical profession in New South Wales have been passed during the year. The activities of Governments and legislative bodies in Australia and elsewhere in the Empire in regard to the extremely important question of the control of venereal diseases have been followed. In particular the Final (1916) Report of the Royal Commission in the United Kingdom, the Western Australian Act, No. 55, of 1915, and the Venereal Diseases Report, of May 26, 1916, of the (Trade and Customs) Committee concerning causes of Death and Invalidity in the Commonwealth, have been the subject of careful study by the Council. It is noted also that Acts have been passed in Victoria, Tasmania and Queensland during the last few months dealing with this subject. The general aim of the enactments is that all cases of venereal diseases shall be subjected to skilled treatment. The means proposed for attaining this object differ to some extent, but, in every instance, the responsibility of effecting it is entrusted to the medical profession, to the exclusion of the unqualified practitioner, the prescribing pharmacist, and the advertising quack. So far as New South Wales is concerned, there is no indication that the administration will seek additional statutory powers at present; but it seems likely that the excellent work done by the Royal Prince Alfred Hospital during the last two years through its Venereal Clinic will be taken up by other metropolitan hospitals under arrangement with the Government, and that the subsidized hospitals throughout the State will be called upon to deal with the cases in their respective localities.

War Emergency Organization.—In the last Report of the Council this subject was dealt with under the following heads, namely: (1) Civil practice; (2) attendance upon soldiers enlisted for active service after discharge from hospital in country and other districts where no military hospital is established; and (3) classification of members for A.A.M.C. purposes. During the year now passed the Defence Department has continued to avail itself of the machinery of the Branch in many ways, and much work has been done. (a) Rosters of members were arranged for the examination of recruits at the Victoria Barracks and at the Town Hall, and these were subsequently combined, to enable the work to be done at the Victoria Barracks only. A supply of members for resident service in the Field Hospitals was organized, and several medical officers were supplied for the oversea transport service. (b) In connexion with the Proclamation of September 29, 1916, for compulsory service under the Defence Act the Branch nominated, in accordance with the War Service Regulations, 1916 (Reg. 32), two members for appointment on the "District Medical Committee," which dealt with the matters referred to it until the Proclamation was revoked on November 22, 1916. (c) The "State Medical War Committee," constituted on September 10, 1915, under the authority of the Federal Parliamentary War Committee to act in connexion with the State War Council, has been called upon to deal with a number of cases of disabled soldiers, after their discharge from the service. The members of this committee, in association with the Superintendent of the Blind Institution, the Superintendent of the Deaf and Dumb and the Blind Institution, the Under Secretary, Department of Public Instruction, and the Director of Technical Education, have been constituted to be "the Disablement Subcommittee of the State War Council," and have taken an active part in the work of rehabilitating ex-soldiers whose injuries have unfitted them for their previous avocations. (d) The Council gave careful attention to a proposal of the Northern Suburbs Medical Association that all mem-

bers of the Branch should accept a commission in the A.A.M.C. Reserve; and concluded that the most appropriate and probably the only effective way of attaining the object sought was the enrolment of all members of the profession, in the other States as well as New South Wales, for service in the Australian Army Medical Corps. It has therefore arranged for the matter to be discussed at the annual meeting of the Branch, under a proposal for a recommendation to be made to the Federal Government for the enrolment of all members of the profession, with a view to their being liable for service, if called upon, and for the establishment of committees for the regulation of the profession with due regard to the needs of the service, the requirements of the civil population and the claims of the individual practitioners subject to the liability.

Removal of Alien Enemies from the Medical Register.—On the suggestion of the Annual (1916) Meeting of the Delegates

of the Affiliated Local Associations of Members with the Council, the Council approached the New South Wales Medical Board and conveyed to the President and members its opinion that it was in the interests of the public and the medical profession that the names of all persons registered in virtue of German or Austrian qualifications who were not resident or practising in New South Wales, and of all persons registered who have been interned as alien enemy subjects or otherwise should be removed from the Register of Medical Practitioners. It is understood that the Medical Board had already, on its own initiative, decided to approach the Government in the matter; but owing, first of all to the illness of the President of the Board, Sir Philip Sydney Jones, and later to the dissolution of Parliament, it now appears that this has not yet been done.

SINCLAIR GILLIES,

President.

New South Wales Branch of the British Medical Association.

Receipts and Expenditures for the year ended December 31, 1916.

RECEIPTS.		EXPENDITURE.	
	£ s. d.		£ s. d.
To Balance from 1915..	250 14 6	By Parent Association <i>re</i> <i>British Medical Journal</i>	953 18 6
" Subscriptions ..	3,343 4 0	" <i>The Medical Journal of Australia</i> ..	880 0 0
" Donations ..	6 3 0	" Rent ..	£150 0 0
" Parent Association ..	2 18 0	<i>Less contra</i> ..	52 7 6
" Sales C.F.A. ..	6 11 8		97 12 6
" Interest ..	20 19 11	" Clerical Assistance ..	706 5 0
		" Premises Account ..	200 0 0
		" Printing ..	106 0 5
		" Stamps ..	72 0 1
		" Telephone ..	19 10 1
		" Assistant Librarian ..	52 0 0
		" Balopticon and Fittings ..	161 19 0
		" Roneo File ..	14 14 0
		" Duplicator ..	6 4 0
		" Sundries ..	37 13 10
		" Attendance, etc. ..	20 14 6
		" Exchange ..	£12 11 0
		<i>Less contra</i> ..	5 1 0
			7 10 0
		" Dr. Balance Petty Cash Account, 1915 ..	1 10 1
		" Balance ..	£292 13 8
		" Balance Petty Cash ..	0 5 5
			292 19 1
	£3,630 11 1		£3,630 11 1

(Sgd.) W. H. CRAGO,
Hon. Treasurer.

Auditors,
(Sgd.) FRED. W. HALL.
(Sgd.) A. MAITLAND GLEDDEEN.
March 5, 1917.

The Honorary Treasurer moved that the financial statement be adopted. He pointed out that the financial position of the Branch was a satisfactory one. The sum for the purchase of the *balopticon* and the amount spent on the premises were the heaviest items of expenditure. In dealing with the Premises Account, Dr. Crago stated that the accumulated funds amounted to £2,460, and to this must be added £1,051 paid by the Association and £1,073 handed over from the *Australasian Medical Gazette*, making a total of £4,584 of incomings. As usual, the sum of £1,000 had been paid off the mortgage. The year had ended favourably, and he was pleased to announce that the year's balance amounted to £738. A suspense account had been started for the purpose of retaining the membership of those members who were on military service abroad, and were in arrears in their subscriptions.

The motion was seconded by Dr. T. W. Lipscomb. Dr. E. A. R. Bligh asked whether it would not be possible for the Branch to pay the subscription of men on active service. Dr. F. Guy Griffiths pressed this matter, and urged the members to see that the subscriptions of the men at the front were either remitted or paid for them. He felt that the idea of the suspense account really meant that

when the men came back they would be asked to pay up any arrears. He could not agree to this.

It was explained that the Council had this matter under consideration. Enquiries were being made as to what the British Medical Association in London proposed to do in these cases. If the amount claimed from London in respect of members on active service were small, a satisfactory solution could be found without difficulty. The chief difficulty lay in the fact that two journals were being supplied, and these journals cost money to produce. Dr. Griffiths agreed to leave the matter in the hands of the Council. Dr. R. A. P. Waugh asked whether *The Medical Journal of Australia* had been supplied to the men on active service. He had experienced that very few had received copies. It was stated that a copy of the *Journal* had been sent to every member whose address was known each week. The non-delivery must have been due to the failure of the postal arrangements.

The motion was carried.

Dr. W. H. Crago, Honorary Treasurer, moved:—

That the thanks of the meeting be conveyed to Dr. F. W. Hall and Dr. A. Maitland Gleddeen for their services as auditors.

The motion was seconded by Dr. A. J. Brady, and carried. Dr. Sinclair Gillies, the President, delivered his Presidential Address. (See page 287).

Dr. R. Gordon Craig asked the members to express their thanks to the President for his Address. He referred in a few well chosen words to Dr. Sinclair Gillies' ability to record the year's work in a masterly manner. He had been exemplary in his attendance at the meetings of the Council and the Committees, and had shown tact and wisdom in the discharge of his duties as President throughout the whole period of tenure of his office. The vote of thanks was carried by acclamation.

The President announced the result of the election of members of the Council as follows:—

President: Dr. R. Gordon Craig.

Vice-President: Dr. C. B. Blackburn.

Council: Drs. G. H. Abbott, George Armstrong, A. J. Brady, W. H. Crago, A. Davidson, J. Adam Dick, Sinclair Gillies, Sydney Jamieson, T. W. Lipscomb, W. F. Litchfield, A. A. Palmer, F. Antill Pockley, F. P. Sandes, R. Scot-Skirving, D. Thomas, R. H. Todd, and R. B. Wade.

Dr. T. W. Lipscomb moved:—

That the thanks of the meeting be conveyed to the Scrutineers, Dr. A. Spiller Brandon, Dr. J. G. Edwards, Dr. A. J. Gibson, Dr. A. Maitland Gledden, Dr. H. S. Marsh, and Dr. Archie Aspinale.

The motion was seconded by Dr. R. A. P. Waugh, and was carried.

Dr. W. F. Litchfield moved that Drs. F. W. Hall and A. Maitland Gledden be appointed the auditors for the ensuing year. The proposal was seconded by Dr. A. Davidson, and carried.

Dr. F. Barrington moved that Lieutenant-Colonel J. Adam Dick be elected the representative of the New South Wales Branch of the Representative Meeting, 1917. Dr. Sydney Jamieson seconded the motion, which was carried.

Sir Herbert Maitland moved that the members of the Committee of the Medical Benevolent Fund of New South Wales be re-appointed for the year 1917. The Trustees were Dr. Robert Faithfull and Dr. F. W. Hall, the Honorary Secretary was Sir Herbert Maitland, and the members of the Committee were Dr. F. W. Hall and Dr. J. M. Gill. The motion was seconded by Dr. A. J. Brady and carried.

Dr. Sinclair Gillies moved on behalf of the Council:—

In grateful recognition of the loyal and devoted services rendered at this supremely critical period to His Most Gracious Majesty the King, and to the Empire, by Members of the Association, it is hereby resolved that the names of all Members who have already enlisted, or who, before the termination of the War, shall have enlisted for Active Service in the Naval or Military Forces of the Empire, shall be enrolled by the Council in a suitable book to be preserved in the Library of the Association.

He pointed out that the Council had recognized that steps should be taken to erect a permanent memorial to the men who had given their services to the Empire. The ultimate form of this memorial would, no doubt, be a suitable tablet on their walls, on which the names of all the men who had served would be inscribed. It was, however, impossible at present to complete the list, and it was of the utmost importance that the memorial should be accurate and complete. The Council had therefore determined to place a Roll of Honour in the form of a book in the Library, where it might be viewed by all, and where it could be preserved as an historical record. The form of book had not been determined, but he mentioned that it might be kept under a glass case, with some form of mechanical arrangement whereby the members could turn over the leaves by turning a handle from the outside. Over 300 of their members had gone to the front. He was of opinion that the proposal of the Council was the best that could be done for the present.

Dr. A. J. Brady, in seconding the motion, raised the question as to what constituted "active service." He held that while the small services of those who had made no real sacrifice could not be included, many of the men who had

given up their practices to take on whole-time work within the Commonwealth should be included. He suggested that a copy of the book might be presented to the Mitchell Library.

The motion was carried.

Dr. R. H. Todd, the Honorary Secretary, moved on behalf of the Council:—

That, with the objects (1) of establishing equality of obligation among medical practitioners in Australia to undertake military service for the purpose of the War, and (2) of maintaining the Australian Army Medical Corps in such a state of efficiency as will enable it to meet the requirements of the Army, due regard being had, at the same time, to the needs of the civil population for medical attendance, it be a recommendation

(a) that steps be taken to introduce compulsory enrolment of all medical practitioners registered as legally qualified medical practitioners or entitled to be so registered in any State, as persons liable for enlistment and service as Officers in the Australian Army Medical Corps; and

(b) that a Medical War Committee be constituted for each Military District in the manner indicated in the Memorandum of the Director-General, Australian Army Medical Corps, of 2nd October, 1916, to make selection for and recommendation for exemption from Australian Army Medical Corps service of the persons so enrolled, and to have such other functions and powers as will enable it to undertake the organization of the medical profession in the District in relation to the needs of the Australian Army Medical Corps and of the civil population.

In the course of a long speech, Dr. Todd followed the history of medical profession in the State and in the Commonwealth in relation to the war. He held that it was the duty of the medical profession at home to the country, to themselves, and to their colleagues to do all that lay in their power to render the full strength of the profession available for the war. The Council had considered how this could be done. During the two and a half years the Branch had done all it could; that all was a great deal. In the early days a war emergency classification of the members had been undertaken in all the States. This classification had enabled them to find out what each man would be able to do. There never had been so big a response to any circular enquiry before. In New South Wales over 600 papers had been returned. The information contained in the returns had served as the basis of much of what had been done. A copy had been given to the Federal authority, and from the list a selection had been made. In addition to this, they had been instrumental in securing men to examine recruits in Sydney, and to perform a variety of different services in field hospitals and elsewhere. They had made full arrangements with the members for the attendance on returned soldiers in places where there were no military hospitals and in the men's homes. Although the Government had proposed to pay for this service, the profession had taken a large-minded view of the matter, and had passed a resolution unanimously to give these services gratuitously. In addition, they had co-operated with the Red Cross Society and had done many other things to facilitate the work of the Defence Department.

The speaker then reviewed the events connected with the Proclamation for universal service of September 20, 1916, and with the memorandum issued by the Director-General of Medical Services. He reminded his audience that a Committee had been set up by this memorandum to regulate the profession for the purpose of making a suitable selection of practitioners who should be called upon to serve in the Australian Imperial Force. In connexion with this scheme he called attention to the bodies which had been created in the United Kingdom, for the purpose of enrolling every member of the medical profession and supplying the military service with its requirements.

He then came to the black cloud of the negative vote on the referendum. The reply of the majority had filled the hearts of all loyal people with dismay and humility. The reply had caused bitter disappointment among their col-

leagues at the front. He read some extracts from communications he had recently received from Lieutenant-Colonel J. Adam Dick, to illustrate how deeply they felt the position in France. An attempt had been made to remove the stain of the "No" vote. Dr. E. A. R. Bligh had been the first to move energetically in this matter, and had opened up a campaign in the northern suburbs of Sydney. He had asked every man to take a commission in the Army Medical Corps Reserve. A meeting of the Northern Suburbs Medical Association had been held on November 11, 1916, and at this meeting it was resolved unanimously to support Dr. Bligh's proposal. Colonel Stokes and Sir Thomas Anderson Stuart had spoken strongly in favour of the scheme at the meeting. Dr. Bligh had then communicated with every other local medical association in the State, with the result that many had already determined to follow suit. The South Sydney Medical Association had passed a similar resolution, and of its 26 members 19 had already applied for commissions. The Eastern and the Western Suburbs Medical Associations, the Northern District Medical Association, the Central Southern Medical Association, and the Western Medical Association had discussed the subject, and had passed the resolution. It was very encouraging to have seen in *The Medical Journal of Australia* of March 24 and 31, a long list of names of men who had obtained commissions in the Reserve. There were already 59 names from New South Wales alone, and others were waiting for their names to appear in the *Commonwealth Gazette*.

All this was encouraging, but it was not enough. The Council had considered the position very carefully, and had come to the conclusion that something should be done to regulate the work of the profession. They had asked for the appointment of a committee similar to the committee which had been created under the Director-General's scheme. It was recognized that no civil body could stand between a junior officer and his superior officer in the Army. The Committee proposed would be a committee of enrolment, and would counsel the military authority in regard to enlistment. It was not an original idea; it had been tested in the United Kingdom, and had been found to work well.

Referring to the motion, he called attention to the fact that no mention was made of the Australian Imperial Force. Dr. Todd was convinced that the Minister of Defence had no power to grant compulsory enlistment or even compulsory enrolment of members as persons liable for enlistment for service outside Australia. He admitted that they all desired to make the medical profession available for overseas service as well as for home service, but he also recognized that the military camp and the field hospital were the best recruiting ground, and if they could obtain what they were asking for, a great deal would be gained. He thought that if the motion were passed, and if the scheme were put into effect, it would go a long way toward the removal of the dark cloud. They would thus dissociate themselves from those who had refused to do what was necessary. If this Committee were appointed, they would have to deal with those men who had not yet applied for a commission. This residue included men who could not undertake military duty away from their practices. These men should support the scheme, for they would not be touched. It also included the men who could be serving, but were not. These men, too, should support the scheme. They lack courage to make up their minds to do the right thing, and this scheme relieved them of the necessity of making the choice. It would operate indirectly on the men already in the Reserve. If all were compelled to enrol, the services would be distributed fairly. There would be equality of obligation. At present there was a moral obligation, but under the scheme the obligation would be a legal one.

Dr. Todd contended that the present was not the time to find fault with the administration. They should do all they could to improve it, and to enable those in authority to burst through the bonds of red tape. He commended the motion to all present, and as a final word pointed out that the obligation after all would be a very slight one.

Dr. R. Gordon Craig seconded the motion. He said that if they were to get any lesson from the war at all, they

must be prepared to meet any emergency that might befall Australia. He would have wished that the proposal had been wider. But no one could foresee what circumstances might arise in the future. They must be prepared to face any emergency. He held that the proposal was but a logical sequence of events. The voluntary method had worked magnificently, and they were all proud of the medical profession for having responded so well. But the burden had fallen on the few and had been an unequal burden. The motion, if passed, would remove this inequality. Some men hung back because they feared to place themselves unreservedly in the hands of the military administration. It was extraordinary how few had suffered an injustice or hardship up to the present, in view of the large task the authorities had been called upon to carry through, and the unpreparedness at the start. It was absolutely necessary for them to place themselves in the hands of the military authorities, but they should remember that a service was always greater than its administration. The District Medical Committee would be able to see that the services would be properly distributed. In conclusion, Dr. Craig regretted that it was legally impossible to extend the scope of the resolution to include service in the Australian Imperial Force.

Dr. G. S. Thompson objected to the resolution on the ground that no mention of the Reserve was made. He was suspicious that it meant the thin end of the wedge of conscription. He had offered his services voluntarily, but was opposed to compulsion. Thirdly, he wished to know what guarantee they would receive that they would not be sent abroad. He was disinclined to accept the word of the Government.

Dr. R. A. P. Waugh explained to the last speaker that in the motion only the Australian Army Medical Corps was mentioned, not the Australian Imperial Force. This meant that under the scheme no one could be required to serve overseas without his consent. He was glad to say that the motion did mean the thin end of the wedge. Dr. Waugh complained that rumours were spread about that men were wanted for service abroad, but that no request had yet been given officially. If an official request for more men were issued, the men would come forward without hesitation. He supported the motion. Men would willingly do their share, but were frightened of the men in the next street.

Dr. H. B. Oxenham stated that he had previously not been in agreement with the scheme of voluntary enlistment, because he held that hardships were imposed on some, while others equally able to make the sacrifice had escaped altogether. He was in complete sympathy with the motion, because it would place all practitioners on an equal footing.

Dr. E. A. Bligh maintained that what was really required, and what the proposal provided was organization. Up to the present 25% of the medical men in the State had gone on service abroad. It was, in his opinion, "up to some of them" to help the men at the front, and to take their places. He was in accord with the motion, but felt that it did not go far enough. He therefore wished to move an amendment, to insert after the words "of maintaining the Australian Army Medical Corps" the words "and Australian Imperial Force," and after the words "for enlistment and service" the words "at home and abroad." He submitted that everyone present wished that there had been a "Yes" vote. They all wanted to be at the front, doing their "bit." Why should they stop at the point of service at home, when they wanted to provide men for service abroad? It was necessary to organize the profession properly, and to arrange for those who were wanted and who were suitable to go abroad. A short Act of Parliament would remove the legal difficulty in the way, and he had great hopes that the authorities would see their way to pass this measure. He spoke very earnestly for the introduction of a complete scheme of compulsory enrolment.

Dr. F. W. Kane seconded Dr. Bligh's proposal. He heartily supported the suggestion to extend the scheme to service outside the Commonwealth.

Dr. J. W. van R. Hoets thought that it would be a pity to press any scheme if no good could come of it. Dr. Todd

had told them that the authorities had no power to grant Dr. Bligh's proposal. A previous speaker had spoken of the thin end of the wedge of conscription. He reminded his audience that before the referendum had been taken, a resolution had been passed by an unanimous vote in that room in favour of conscription. It was only consistent if they, as members of the medical profession, were to offer themselves as a body to be made use of by the military authority. Some men could not go, but if a scheme embodying compulsion were introduced, the responsibility would be removed from these men. He favoured the amendment, if it were practical.

Speaking to the amendment, Dr. R. Gordon Craig admitted that he was greatly biased in favour of extending the enrolment so as to render the whole profession liable for service with the Australian Army Medical Corps, both at home and abroad. He had not referred to the Australian Imperial Force before, because it was not included in the motion. Dr. Bligh's amendment was much more to his liking.

Dr. T. W. Lipscomb was in sympathy with Dr. Bligh, but thought that it was necessary to look at the matter in a practical light. He was afraid that by pressing the amendment, they might kill the whole scheme. An Act of Parliament was necessary to give effect to Dr. Bligh's amendment, whereas nothing of the sort was required for the carrying into action of the original proposition. A proclamation was all that would be needed. Politicians one and all had declared that they would not raise the question of conscription again.

Dr. Sydney Jamieson urged members not to be led astray. What did it matter whether it was legal or not? He was glad to say that they were neither lawyers nor politicians. They wanted to dissociate themselves from the spirit of that body that called itself the Imperial Workers of the World. He wanted members to vote for Dr. Bligh's amendment, because it was what they all desired. The authorities must be held responsible for the machinery. They had nothing to do with that. Let them tell the authorities that the medical profession was prepared and anxious for compulsory service and was desirous of obtaining it as a body, apart from the rest of the community. The authority could determine whether their proposal was practical or not.

Dr. Archie McLean considered that a spontaneous gift from the medical profession would be of immense value to the community. He supported Dr. Bligh's amendment. He had recently returned from England, and had been struck in coming back to sunny Sydney to note the vast difference between things here and there. In New South Wales there was plenty of money and plenty of food. Moreover, he held that the passage of the amendment might have a cumulative effect. If the doctors passed it, the lawyers might follow suit; then the sports clubs would come in and eventually they might get a general demand for conscription throughout the Commonwealth. He would be proud if the Association could take the lead in this movement.

Dr. A. J. Spiller Brandon hesitated before giving his vote pledging all medical practitioners throughout the State to this highly desirable scheme, while only one-twentieth of the number was present. He thought that British justice would demand that if the "blacklegs" were to be included, they should at least be allowed to have a voice in determining the policy. He therefore did not think it a fair thing to press the amendment.

Dr. F. P. Sandes sympathized with Dr. Bligh, but thought that it was unwise to press the amendment. He asked Dr. Bligh to withdraw the amendment to enable the original motion to be passed first, and if he cared to do so, he might move it as a separate motion later. They wanted to make sure that the smaller demand was not sacrificed in a vain endeavour to secure the larger.

Colonel E. S. Stokes, the Principal Medical Officer, No. 2 Military District, stated that he was at all times anxious to see men offering themselves for military service at home and abroad. Since the matter under discussion involved an alteration of the military regulations, he felt himself precluded from taking any part in the discussion.

Dr. Archie Aspinall wanted to be assured that the amendment represented the view of the rest of the members of the New South Wales Branch.

Dr. Bligh asked leave to withdraw his amendment, on the understanding that he would have an opportunity of asking the members later on to allow him to move it as a rider. Permission was granted.

Dr. Sinclair Gillies explained that the motion before the meeting did not involve the members in direct compulsory enlistment. What the Council asked the members to approve of was that all members of the profession should be compulsorily enrolled as persons liable for enlistment for service within the Commonwealth. The Committee could deal with the men enrolled and recommend to the military authorities which men might be used for military purposes without disturbing the arrangements for providing medical attendance on the civil population.

The motion was put to the meeting, and was carried unanimously. The result evoked loud applause.

Dr. E. A. Bligh then asked leave to move a rider to the effect that the members present expressed the wish that the enrolment should be extended to include compulsory service in the Australian Imperial Force as well as in the Australian Army Medical Corps. Permission was given, by a considerable majority. Dr. Bligh spoke strongly in favour of asking for what they really wanted. He suggested that they should give the Federal Committee the opinion of the meeting.

Drs. Waugh, Woolnough and Lipscomb suggested that the question should be referred to the members. Dr. Todd pointed out that the referendum was a dangerous instrument and that it was always doubtful whether the real opinion of any body of men could be obtained by its means. He hoped that the meeting would not use it. Considerable doubt was expressed by some members whether the meeting was justified in pressing for a decision on this point, in view of the fact that no notice of motion had been given. After many members had spoken, Dr. Bligh begged leave to withdraw the rider. He would prefer to leave the matter where it was at present, as the members would have a chance of thinking it over. He would give notice to bring the subject up at the next meeting, and he was hopeful that it would then be carried by all present.

The business of the meeting was terminated after Dr. Sinclair Gillies had called upon Dr. Gordon Craig to replace him in the Presidential Chair. He did not think it necessary to say anything in recommending Dr. Gordon Craig to the members. On taking the chair, Dr. Gordon Craig expressed the hope that the members would have the same sympathy with him that he had had with Dr. Sinclair Gillies.

MEDICO-POLITICAL.

A meeting of the Council of the Western Australian Branch was held in Perth on March 18, 1917. The following office-bearers and members of the Committee, etc., for the year 1917 were elected:—

President: Dr. J. K. Couch.

Vice-President: Dr. R. C. E. Atkinson.

Ex-President: Dr. R. C. Merryweather.

Members of Council: Dr. Dixie P. Clement, Dr. F. A. Hadley, and Dr. E. A. Officer.

Members of Ethical Committee: Dr. R. C. E. Atkinson, Dr. Dixie P. Clement, and Dr. R. C. Merryweather.

Honorary Auditors: Dr. M. K. Moss, Dr. A. E. Randell.

Honorary Treasurer: Dr. W. Trethowan.

Honorary Secretary: Dr. G. H. Shearman.

Dr. Charles W. T. Woods resigned his position as Honorary Secretary after four years of strenuous work. The Council regretted that Dr. Woods had requested to be relieved of his office, and placed on record their appreciation of his valuable services.

A crisis has occurred in the affairs of the Brisbane General Hospital. For some time past the Committee have been unable to meet the liabilities of the Institution. The overdraft at the Bank stood at £7,142, while the assets and securities amounted to £5,459. The liabilities at the end

of March amounted to £9,842. Repeated applications to the Government for assistance had been made without avail. On March 20, 1917, the Committee decided to resign in a body, and to place the onus of conducting the Institution on the shoulders of the Government. A deputation waited on the Acting-Home Secretary on March 22, 1917, when it was pointed out that every possible means of raising funds had been tried without success. The Minister stated that he had discussed the position with the Secretary of the Hospital Committee, and that he had pointed out that the action of the Legislative Council in throwing out the Hospital Bill had placed the Government in a very difficult position. The resignation of the Committee took effect on March 31, when the Government took over the management. It has been stated that the Hospital Bill will be re-introduced next session.

The death of Dr. Colin C. McDonald, of Mount Gambier, South Australia, occurred on February 28, 1917, after a long illness.

Correspondence.

THE MEDICAL PROFESSION AND FRIENDLY SOCIETIES.

Sir,—Your leader in to-day's issue is the best thing written on the subject up to the present, and clearly shows that the model lodge agreement is not a basis of negotiation, but the absolute minimum of conditions upon which lodge surgeons can carry on their work. The correspondence on the subject has been remarkable, in that only one doctor wrote against our view, but took the first opportunity to tell us manfully that we had the facts. We therefore claim that there is strong determination on the part of lodge surgeons to get this matter righted.

When I began this correspondence, it was with a feeling of despair of anything good coming out of the B.M.A. Six lodge surgeons and 26 Collins-street men attended the annual meetings, and I had, for the *nth* time, resurrected the lodge question to an unresponsive audience.

I asked, in that letter, for more interest in the doings of the B.M.A., and a 100 per cent. attendance of lodge surgeons at the meetings. The Council has an item, "General Business," at every general meeting, and any member can bring forward any topic for discussion.

Surely the problems affecting us are so great that I shall not be compelled, as "Doctor's Wife" suggests, to lead with flying banner, the large army of doctors' wives (and I here confess I need their aid at this moment), in order that their apathetic husbands shall devote two hours of the time given to their patients to the interests of their own families, their own lives, and their own practices, once a month. "Herodotus" complains that the B.M.A. is of no good to him. I agree with him. While the policy of the members is to stay away from meetings, when election time comes round, they vote for names, not men. How many men knew, when they voted Dr. F. L. Davies off the Council last election, that he is one of the best lodge men we ever had there?

There is no reason in the remark our members make: "What do I get out of the B.M.A.? I pay my 3 guineas, and I get nothing." The answer is: "Come to meetings, all of us, and bring the men nearest you. If you can speak, well and good; if you cannot, your vote is as good as the biggest specialist's vote, and, after all, a vote, and not talk, is the only thing that counts. This is the only way to make the B.M.A. do something for its members."

Twelve months ago I moved that a referendum be taken of the men in Victoria, with a view to securing the Model Lodge Agreement. Defeated by 54 to 4. The four were Amess, Jona, Ostermeyer, and my self. Where were the rest of the lodge surgeons? Where will they be when the next vote comes? I trust the whole 100 per cent. will be there.

I have been talking the lodge question for eighteen months, and I write with a bitter heart, for I meet lions in private discussion, and will-o'-the-wisps on the first Wednesday in the month, when the B.M.A. meets. There

is to be at last a conference between the representatives of the B.M.A. and the lodges shortly. Let us thank our Council for it, for at last we move ahead.

But there will be meetings to discuss their proposals. Therefore, for your own conscience's sake, let us fill the hall in Albert-street to the full, so that we can give encouragement to the fighting minority for us, and enlightenment to these not so enthusiastically with us.

I thank you for your kindness in allowing me to have the last word on the subject till the conference is over. I trust that our representatives will secure for us our minimum, the Model Lodge Agreement.

Yours, etc.,

D. ROSENBERG.

267 Church-street,
Richmond, Victoria.
24.3.1917.

[This correspondence is now closed.—Ed.]

THE SOUTH AUSTRALIAN BRANCH.

Sir,—In your issue of March 25th, 1917, "Another Country Med." makes a statement, which casts a grave reflection on the working of this Branch. I should like to state that, to my knowledge, only one request has come from a member concerning Lodge proposals, and that was answered within three days of receipt.

Had "Another Country Med." really desired the information, it would have been more courteous to write and ask whether his letter had been received, rather than make ill-natured insinuations anonymously.

Yours, etc.,

A. CAMPBELL MAGAREY,
Acting Hon. Secretary,
South Australian Branch,
British Medical Association.

Adelaide,
28th March, 1917.

TREATMENT OF CARBUNCLE.

Sir,—Dr. J. Forbes Mackenzie has rendered excellent service to modern surgery by directing attention to this painful and in many respects serious lesion.

The traditional treatment by warmth and moisture, followed by "crucial incisions or straight incisions, or incisions uniting the small openings already in existence, without or with the use of pure carbolic acid, or cutting with scissors and scraping away of superficial necrosed tissue" are all methods crude, cruel and slow, and invariably followed by scarring contraction and deformity.

The essential point in the pathology of this disease, apart from causation, is the line of demarcation, or "nature's barrier," between healthy and unhealthy tissues. It will come as a revelation to Dr. Mackenzie—yet I submit the fact with undiluted confidence—that incisions, as surgically understood, are unnecessary in the successful treatment of carbuncle.

In my special practice I now rarely see cases of carbuncle, but the present seems an opportune occasion for recording one's plan, based upon a most careful observation of a series of cases. It is wondrously simple and easy of application, rapid in effect and efficient in cure, both from a surgical and, if one may use the term, æsthetic standpoint.

The area surrounding the crater should be painted with tincture of iodine. The crater itself should then be moistened with a small quantity of a 10% solution of cocaine on cotton wool, or sprayed with ethyl chloride.

Multiple punctures with a large surgical needle may be rapidly performed in the softened crater, and may be completed in less than thirty seconds. The punctures must not be deep. A Bier's cup (cost 5s.) of correct size, and with the margin protected by soft rubber—though this is not essential—should be applied over the carbuncle. Immediately a large amount of purulent, sloughy, blood-stained discharge will be withdrawn. By taking advantage of gravity there will be little or no fouling of adjacent skin. The cup should be applied by the nurse two or three times a

day: The crater should be filled with sodium citrate carefully powdered, moistened with hypertonic salt solution. A preparation of 10% ichthylol in vaseline should be freely smeared over the whole reddened area each time the lesion is dressed. Plain, soft, sterile lint forms the best cover, a hole being cut in its centre over the crater for freer escape of discharge into the dressing pad finally applied.

The results will exceed the most sanguine expectation of those accustomed to follow older and more crude and painful methods.

No incision is necessary, therefore no raw, tender surface is created.

The principles involved are sound, and conform to correct physiological view. Concentrated antiseptics and escharotics are more harmful than good.

The essentials are to relieve tension by the simplest means, to release and withdraw virulent factors and softened necrotic substances, and to promote healing and anabolism by flooding the tissues with patient's own healthy serum. I am grateful to Dr. Mackenzie for this opportunity of placing my observations before the profession.

Yours, etc.,

WILLIAM T. CHENHALL, M.D., F.R.C.S.E.
Sydney, March 8, 1917.

Medical Appointments.

Dr. Thomas Hugh Donnelly has been appointed Public Vaccinator for the South-Western District, Victoria, a vacancy created by the death of Dr. M. F. Kelly.

It is announced that Dr. Percy Herbert Liddle has been appointed Trustee for Daylesford Public Cemetery, Victoria.

Dr. Francis B. Crawford has been appointed Certifying Medical Practitioner at Ballarat East for the purposes of the Shops and Factories Acts, in place of Dr. Paul G. Dane, resigned.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xxiii.

Brisbane Hospital, Junior Resident Medical Officers.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
VICTORIA.	
(Hon. Sec., Medical Society Hall, East Melbourne.)	Brunswick Medical Institute. Bendigo Medical Institute. Pahran United F.S. Dispensary. Australian Prudential Association Proprietary, Limited. National Provident Association. Life Insurance Company of Australia, Limited. Mutual National Provident Club.

QUEENSLAND.	
(Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Brisbane United F.S. Institute.

Branch.	APPOINTMENTS.
SOUTH AUSTRALIA.	
(Hon. Sec., 3 North Terrace, Adelaide.)	The F.S. Medical Assoc., Incorp., Adelaide.
WESTERN AUSTRALIA.	
(Hon. Sec., 239 St. George's Terrace, Perth.)	Swan District Medical Officer. All Contract Practice Appointments in Western Australia.
NEW SOUTH WALES.	
(Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Department of Public Instruction—Appointments as Saluried Medical Officers, with duties which include the treatment of school children. Australian Natives' Association. Balmmain United F.S. Dispensary. Canterbury United F.S. Dispensary. Leichhardt and Petersham Dispensary. M.U. Oddfellows' Med. Inst., Elizabeth Street, Sydney. Marrickville United F.S. Dispensary. N.S.W. Ambulance Association and Transport Brigade. North Sydney United F.S. People's Prudential Benefit Society. Phoenix Mutual Provident Society. F.S. Lodges at Casino. F.S. Lodges at Lithgow. F.S. Lodges at Orange. F.S. Lodges at Parramatta, Penrith, Auburn, and Lidcombe. Newcastle Collieries — Killingworth. Seaham Nos. 1 and 2, West Wallsend.
NEW ZEALAND: WELLINGTON DIVISION.	
(Hon. Sec., Wellington.)	F.S. Lodges, Wellington, N.Z.

Diary for the Month.

Apr. 10.—N.S.W. Branch, B.M.A., Council (Quarterly).
Apr. 10.—Tas. Branch, B.M.A., Council and Branch.
Apr. 12.—Vic. Branch, B.M.A., Council.
Apr. 13.—N.S.W. Branch, B.M.A., Clinical.
Apr. 13.—Q. Branch, B.M.A., Branch.
Apr. 14.—S. Aust. Branch, B.M.A., Council.
Apr. 17.—N.S.W. Branch, B.M.A., Executive and Finance Committee; Ethics Committee.
Apr. 18.—W. Aust. Branch, B.M.A., General.
Apr. 18.—North Eastern Med. Assoc. (N.S.W.), Annual.
Apr. 19.—City Med. Assoc. (N.S.W.).
Apr. 20.—Q. Branch, B.M.A., Council.
Apr. 20.—Eastern Suburbs Med. Assoc. (N.S.W.).
Apr. 21.—Northern Suburbs Med. Assoc. (N.S.W.), Annual.
Apr. 24.—N.S.W. Branch, B.M.A., Med. Politics Committee; Organization and Science Committee.
Apr. 25.—Vic. Branch, B.M.A., Council.
Apr. 27.—N.S.W. Branch, B.M.A., Branch (Ordinary).
Apr. 27.—S. Aust. Branch, B.M.A., Branch.
May 2.—Vic. Branch, B.M.A., Branch.
May 4.—Q. Branch, B.M.A., Branch.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.
Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.
The Medical Association of Australia should be addressed to "The Editor," *Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.